# Allergy History Form

Patient Name: _____________________________________  Date: ____/____/_______

DOB: ____/____/____

Check Conditions Affecting Symptoms

1. During which months do symptoms occur?

- [ ] All Months
- [ ] January
- [ ] February
- [ ] March
- [ ] April
- [ ] May
- [ ] June
- [ ] July
- [ ] August
- [ ] September
- [ ] October
- [ ] November
- [ ] December

2. Are symptoms worse?

- [ ] Morning
- [ ] Afternoon
- [ ] Evening
- [ ] Night
- [ ] At home
- [ ] At work/school
- [ ] Other, Location ___________________

3. Are symptoms:

- [ ] Constant
- [ ] Erratic
- [ ] Rare

4. Do symptoms interfere with your activities?

- [ ] Not at all
- [ ] A little
- [ ] Moderately
- [ ] All the time

5. Family History:

- [ ] Asthma
- [ ] Eczema
- [ ] Sinus problems
- [ ] Migraine
- [ ] Hay fever
- [ ] Ulcer
- [ ] Nervous disorder
- [ ] Colitis
- [ ] Other: ___________________________________________________________________

6. Your Medical Conditions:

- [ ] High blood pressure
- [ ] Heart disease
- [ ] Asthma
- [ ] Bronchitis
- [ ] Bee sting allergy
- [ ] Thyroid disease
- [ ] Emphysema
- [ ] Diabetes
- [ ] Hormonal difficulty
- [ ] Stomach or intestinal problems/disease
- [ ] Drug allergy, specify: ______________________________________________________
- [ ] Food allergy, specify: ______________________________________________________

7. Do any of the following cause or make your symptoms worse?

- [ ] Milk or milk products
- [ ] Fruit or juices
- [ ] Vegetables
- [ ] Eggs/egg products
- [ ] Beer
- [ ] Wine
- [ ] Wheat products
- [ ] Liquors
- [ ] Nuts/beans/seeds
- [ ] Cheese
- [ ] Meat
- [ ] Mushrooms
- [ ] Vinegar
- [ ] Chicken
- [ ] Poultry
- [ ] Fish
- [ ] Other: ___________________________________________________________________
- [ ] Other: ___________________________________________________________________
- [ ] Other: ___________________________________________________________________
8. Are your symptoms made worse by:

- Wind
- Damp areas
- Insecticides
- Cosmetics
- Weather change
- Cold day
- Indoors, explain: ______________________________________________________________
- Outdoors, explain: _____________________________________________________________

9. Do you have pets or are you exposed to other animals?

- Cats
- Dogs
- Other, list: ___________________________________________________________________

Previous Allergy Treatment

1. Have you ever been treated with Allergy Shots or Drops?

- Yes
- No

If yes, what were you treated for?

- Grass pollens
- Molds
- Tree Pollens
- Animals
- Other: ______________________________

2. Did the Allergy Shots or Drops help you?

- Yes
- No
- Don’t know

3. What years were the shots or drops taken?

__________ to __________

Other Information

Please note below any other information you would like to add

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________