ALLERGY HISTORY

Shashi A.M. Kumar, M.D.

1. **Name:** _____ **Sex:** ____ **Age:** _____ **Date of visit**: _____
Referred by / Primary Physician: _____ **Weight:**_____ **Height:**_____

CHIEF COMPLAINT(S): ***Circle the type of problem(s) for which you seek an evaluation***

Nasal allergies/Sinus, Asthma, Eczema, Chronic cough, Hives, Food allergy, Drug allergy, Reaction to insect sting, Other

ALLERGIES (nose / sinus / eye) symptoms

2. ***How long have you had allergy symptoms ?_____ yrs / mths***

(CHECK THAT APPLY)	none	mild	Mod	severe
a) Runny nose				
b) Sneezing				
c) Nasal congestion				
d) Post nasal drip				
e) Red, itchy & watery eyes				
f) Itchiness of nose				
of throat				
of palate				
of ears				
g) Nose bleed				
h) Sinus headaches				
i) Impaired taste / smell				
j) Recurrent sinus infections				

ASTHMA (chest) symptoms

3. ***How long have you had asthma symptoms ?_____ yrs / mths***

(CHECK THAT APPLY)	none	mild	Mod	severe
a) Cough +/- Phlegm				
b) Wheezing				
c) Shortness of breath				
d) Chest tightness				
e) Symptoms with exercise				
f) Lump in the throat				
g) Choking, Loss of speech				

SKIN (Eczema / Hives)

4. ***How long have you had skin symptoms?*** _____

(CHECK THAT APPLY)	none	mild	mod	severe
a) Hives (Urticaria)				
b) Swellings (Angioedema)				
c) Eczema / Dry skin				

Answer question #5 if you have asthma symptoms. If not skip to question #6

5. =How often do you have daytime asthma symptoms? Always Daily 3-6x per week 2x or less per week sporadic
=Night time asthma symptoms? 5x or more per month 3-4x per month 2x or less per month None
=Number of ER and/or Urgent care visits (specialist or primary care or walk-in clinic) for asthma in the past 12 months _____
=Ever hospitalized for asthma? YES / NO Number of hospitalizations? _____ Last hospitalization _____
=Number of times on oral steroids or injectable steroids (Prednisone, Medrol dose pack, Steroid shots) in the past 12 months ____
=How many days of work or school have you missed due to asthma in the past 12 months _____
=Do you monitor peak flows at home? YES / NO. If so, what is your ideal peak flow? Morning _____ Evening _____
=Do you have stomach reflux symptoms (sour belching, heartburn, pain or difficulty swallowing) YES / NO

6. Do your symptoms vary with the seasons? YES / NO

If YES, place an "X" in the boxes when symptoms are worse

Symptoms	JAN	FEB	MAR	APRIL	MAY	JUNE	JULY	AUG	SEPT	OCT	NOV	DEC
Hay fever												
Asthma												
Eczema												
Hives												

7. Are you up to date on routine childhood vaccinations (immunizations)? YES / NO
Influenza vaccine received: YES / NO when? _____ (Flu)
Pneumococcal vaccine received: YES / NO when? _____ (Pneumonia) (Pneumovax 23 or Prevnar 13)

List over-the-counter and Prescription drugs used: (include dose and frequency of use)

CURRENT **PAST**

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Please continue on the next page

8. ***Check those triggers that cause or worsen your symptoms***

Hay fever	Asthma	Eczema / Hives	Triggers (circle or check all applicable)
			House Dust (Vacuuming, Dusting, Making bed, Shaking bed, Cleaning, sweeping)
			Animals (cats, dogs, hamster, birds, guinea pig, other _____)
			Respiratory infections (Colds, sinus infections, Flu, Bronchitis)
			Exercise
			Night time
			Strong odors (detergents, paint fumes, newsprint, gasoline, diesel fumes)
			Cosmetics, Perfumes, Air refreshners, Cleaners, Hair spray, etc.
			Emotional upset (Stress, Worry), Laughing
			Smoke (Tobacco, Auto exhaust, other _____)
			Cold air (air conditioning or outside air)
			Weather changes: Rain _____, Cold Fronts _____, Thunderstorm _____, Wind_____
			Smog (Air pollution)
			Drugs (aspirin / Ibuprofen, blood pressure medicine, glaucoma drops)
			Grass mowing, Raking leaves
			Foods / Food additives eg: Sulfites (in dried fruits, wine, beer etc) / other _____
			Menstrual cycle, Pregnancy

9. ***Other allergies*****: Food allergy?** YES / NO **Insect Sting allergy** (Bee, YJ, Wasp, Hornets, Fire ants)**?** YES / NO
Drug allergy? YES / NO **Latex rubber allergy?** YES / NO

Have you undergone allergy tests? YES / NO By whom? _____
Please list the results of your allergy testing ?_____
Have you received allergy shots in the past? YES / NO when and how long?_____
Did the allergy shots help your symptoms? YES / NO _____

10. ***Home/Environmental survey*** ***(Fill in the blanks and circle those that apply)***
Years at present address: ____ ***Age of dwelling****: ____* ***Dwelling Type:*** House Apartment Trailer Other _____
Trees around the house: Cedar Oak Maple Elm Pecan Pine Other _____ ***Lawn grass****:* Bermuda Fescue Other _____
Any visible allergens inside the house: Mold-Mildew Roaches Rodents ***Indoor plants:*** Yes / No
Type of heating: Forced air Gas Radiators Electric Wood burning Space heaters Other_____
Type of cooling: Central Window unit fans none ***Humidifier use:*** *(Central / Portable) YES / NO*
Any indoor animals? (Dog, cat, hamster, bird, guinea pig, other _____) ***Outdoor animals?*** (cat, dog, horse, cattle, other_____)
Type of bed: Mattress / Box spring Waterbed Foam other ***Comforter***: Feather / Non-feather
Type of pillow: Foam Feather Down Kapok Synthetic *Water leakage or damage in your home*: Yes / No
Carpets? YES / NO ***Basement present***? YES / NO *If yes, is it Damp*? Yes / No
Latex exposure in the home? Check all that apply (__ Playtex gloves __ Balloons __ Condoms or diaphragm)

11. ***Review of medical problems*** ***(Circle if present)*** Poison ivy/oak dermatitis Chr snoring Sleep apnea Nasal polyps
Heart burn/Reflux Stomach ulcers Hepatitis HIV/AIDS Diabetes Thyroid disorder Weight loss Glaucoma Hypertension
Elevated cholesterol Angina Heart failure Kidney stone Chr bronchitis/Emphysema Chr abdominal pain Chr diarrhea Colitis
Arthritis Migraine Anxiety/Depression Anemia Osteoporosis

12. ***Past history of diseases***: ***(Circle if present) List surgeries _____***
Asthma Eczema/Atopic dermatitis Acute/Chronic hives Thyroid disorder
Recurrent Pneumonia Recurrent Sinus infections Recurrent ear infections Ear tubes
Sinus surgery Tonsils surgery Adenoids surgery Nasal Polyps Migraines

13. ***Family History*** Do any of your family members (parents, siblings, children) have the following conditions?
Hay fever Asthma Eczema Drug allergy Food allergy Chronic hives HAE Colitis
Sinus problems Nasal Polyps Cystic Fibrosis Emphysema Arthritis Migraine Glaucoma
Anxiety / depression Immune deficiency Hypertension Diabetes Thyroid disorder

14. ***Social History***
Marital Status (if applicable): ____ **Pregnant now:** YES / NO ***Occupation***: _____ ***Chemical exposure at work****:* YES / NO
Hobbies: _____ ***Smoking?*** YES / NO ***Year started smoking? _____*** ***Number of Cigg / day _____***
Quit smoking? Year _____ ***Does anyone smoke inside your home?*** YES / NO

History reviewed with the patient in detail *YES / NO* Shashi A.M. Kumar, MD