Patient No._____

Allergy History Survey

Clinic Name_____ **Date**_____

Patient Name_____ **Age** _____ **M/F**

COMPLAINTS:

Please circle the appropriate number 0-3 according to severity: **0 = absent** (no symptoms evident), **1 = mild** (symptoms present, but minimal awareness, easily tolerated), **2 = moderate** (definite awareness, bothersome, but tolerable), **3 = severe**

Nasal discharge (runny nose)	0	1	2	3	Headache	0	1	2	3
Nasal obstruction (stuffy nose)	0	1	2	3	Hives	0	1	2	3
Nasal itching	0	1	2	3	Eczema	0	1	2	3
Sneezing	0	1	2	3	Chronic fatigue	0	1	2	3
Watery eyes	0	1	2	3	Frequent sinus or ear infections	0	1	2	3
Itchy eyes	0	1	2	3	Frequent colds or sore throat	0	1	2	3
Gritty feeling (eyes)	0	1	2	3	Learning disability	0	1	2	3
Cough	0	1	2	3	Poor memory or concentration	0	1	2	3
Wheezing	0	1	2	3	Hyperactivity	0	1	2	3
Shortness of breath, difficulty breathing	0	1	2	3	Arthritis or muscle aching	0	1	2	3
Asthma: Yes No	0	1	2	3	Food intolerance	0	1	2	3

Other symptoms or specific foods causing you problems?

_____

MEDICATIONS:

How often do you take medications for your allergy symptoms?

0 = never, **1 = occasionally** (several times a month or less), **2 = frequently** (several times a week), **3 = daily**

Antihistamines (Claritin, Zyrtec, Benadryl)	0	1	2	3
Nasal Steroids (Flonase, Nasacort)	0	1	2	3
Oral Steroids (Prednisone)	0	1	2	3
Asthma medication (Albuterol inhaler, Singulair, Advair)	0	1	2	3
Eye drops (Patanol, antihistamine/allergy eye drops)	0	1	2	3

Other allergy-related medications _____

Does any medication give you relief of symptoms? _____

Which if any medications are you allergic to? _____

ALLERGY HISTORY:

How many months of the year do you have allergies? _____ What year did they begin?:_____

In what season are they worse: ☐ Spring ☐ Summer ☐ Fall ☐ Winter

Have you been allergy tested before? ☐ Yes ☐ No

If yes, which type: ☐ Skin Prick/Puncture ☐ Serum-Specific IgE (blood draw)

Have you previously received allergy shots? _____ Allergy drops? _____If yes, when? _____

Do you smoke or use tobacco products? _____

List any animals you have in or around the home _____

Who else in your family has allergies? _____

How did you hear about us?

☐ Yellow Pages

☐ Friend (Name:_____)

☐ Newspaper/Magazine (publication name:_____)

☐ Physician (Name:_____)

☐ Website (Name:_____)

☐ Insurance (Co. Name:_____)