

**COMPREHENSIVE ALLERGY SERVICE**  
**New Patient Allergy History Form**

Name _____	Today's Date _____
Date of Birth _____	Account # _____
Referred By _____	

**PLEASE FILL THIS SIDE OF THE FORM.**

**1. Why did you come today?**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**2. Describe Your Symptoms.**

**Nose:** Runny \_\_\_ Stuffy \_\_\_  
          Itchy \_\_\_ Drainage \_\_\_

**Face:** Swelling \_\_\_ Pain \_\_\_  
          Pressure \_\_\_

**Throat:** Sore \_\_\_ Swelling \_\_\_

**Ears:** Infections \_\_\_ Pain \_\_\_

**Chest:** Shortness of Breath \_\_\_  
          Wheezing \_\_\_ Cough \_\_\_

**3. Are Your Symptoms Worse During a Particular Time of Year?**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**If Yes, Which Season**

Spring \_\_\_ Summer \_\_\_

Fall \_\_\_ Winter \_\_\_

**PLEASE LEAVE THIS SIDE FOR THE DOCTORS NOTES.**

Ht. \_\_\_\_\_ Wt. . \_\_\_\_\_ BP . \_\_\_\_\_

**HEENT:**

Nose:

Eyes:

Throat:

**LUNGS:**

**SKIN:**

**EVALUATION:**

Specialist \_\_\_\_\_

Lab Studies \_\_\_\_\_

Special X-Ray Studies \_\_\_\_\_

**IMPRESSION AFTER EVALUATION**

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

**PLAN**

**MEDICATIONS**

- A. \_\_\_\_\_
- B. \_\_\_\_\_
- C. \_\_\_\_\_
- D. \_\_\_\_\_

**ENVIRONMENTAL CONTROLS**

**OPINIONS:**

**4. Are Your Symptoms Aggravated By Exposure to:**

Grass \_\_\_\_\_ Trees \_\_\_\_\_

Weeds \_\_\_\_\_ Dust \_\_\_\_\_

Dogs \_\_\_\_\_ Cats \_\_\_\_\_

Other Animals \_\_\_\_\_

Drugs \_\_\_\_\_ Insects \_\_\_\_\_

Foods \_\_\_\_\_ If Yes, Which Ones

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

4. \_\_\_\_\_

5. \_\_\_\_\_

6. \_\_\_\_\_

**Other Foods**

\_\_\_\_\_

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**5. Past Medical History**

**Who in Your Family Has Allergy?**

**Any Current Medical Problems?**

**How Significant Are the Symptoms?**

**Other Triggers for Symptoms?**

Smoke \_\_\_\_\_

Smog \_\_\_\_\_

Infection \_\_\_\_\_

Emotional Upset \_\_\_\_\_

Family History of Allergy?

Where Problems Managed?

**Any Past Medical Problems**

Where Treated?

**6. WHAT MEDICATIONS ARE YOU CURRENTLY TAKINGS?**

WHAT MEDICATIONS ARE BEING TAKEN AND DO THEY WORK?

- a. \_\_\_\_\_
- b. \_\_\_\_\_
- c. \_\_\_\_\_
- d. \_\_\_\_\_
- e. \_\_\_\_\_
- f. \_\_\_\_\_

- 1. \_\_\_\_\_
- 2. \_\_\_\_\_
- 3. \_\_\_\_\_
- 4. \_\_\_\_\_
- 5. \_\_\_\_\_
- 6. \_\_\_\_\_

**7. Environmental History**

**Where are you living?**

House \_\_\_\_\_ Apt \_\_\_\_\_

Age of Home \_\_\_\_\_

**Type of Heating System?**

Central Force Air \_\_\_\_\_

Space Heater \_\_\_\_\_

Other \_\_\_\_\_

**Do You Have Air Conditioning?**

Yes \_\_\_\_\_ No \_\_\_\_\_

**What Type of Flooring Have You?**

Carpeting Long Pile \_\_\_\_\_

Carpeting Short Pile \_\_\_\_\_

Hardwood \_\_\_\_\_

Linoleum \_\_\_\_\_

**What Type of Bedding?**

Covered Pillow \_\_\_\_\_

Covered Mattress \_\_\_\_\_

Stuffed Animals \_\_\_\_\_

Lots of Books \_\_\_\_\_

Curtains \_\_\_\_\_

Blinds \_\_\_\_\_

**Any Other Information You Wish to Report?**

**SKIN TEST RESULTS**

**OPINION:**

**IMPRESSION:**

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

4. \_\_\_\_\_

**PLAN**

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

4. \_\_\_\_\_

5. \_\_\_\_\_

**FOLLOWUP:**