ALLERGY, SINUS & ASTHMA SPECIALISTS of NAPLES

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MEDICAL HISTORY AND ALLERGY SURVEY

Please complete this form. It is important for your doctor to know the details about your medical history and allergy symptoms. You may use the back of each page to complete your answers.

NAME_____AGE_____APPT. DATE_____

Circle the allergy problems that you have:

(1) Hay fever/sinus (4) Eczema (7) Drug allergy
(2) Asthma/bronchitis (5) Insect allergy (8) Headache
(3) Hives/swelling (6) Food allergy

I. CHIEF COMPLAINT

A. Describe your major allergy symptoms. How do they make you feel?

_____
_____
_____

B. **What are your expectations from this allergy consultation (Please complete)?**

_____
_____
_____

II. SYMPTOMS (check)

Eyes: Itching_____ Swelling_____ Burning_____ Tearing_____ Discharge_____

Ears: Itching____ Fullness_____ Popping_____ Decreased hearing_____ Pain____

Nose: Sneezing____ Itching_____Runny nose_____ Mouth breathing_____

Nasal obstruction_____ Discolored discharge_____

Headache____ Where? _____

Throat: Itching _____ Soreness_____Post nasal drip ____ Throat clearing ____ Swelling ____

Chest: Cough_____ Sputum_____Color and amount_____

Wheezing____ Chest tightness_____ Shortness of breath with exercise_____

Skin: Dermatitis____ Eczema____ Hives____ Swelling____ Rashes____

Where on your body? _____

A. Age and onset of your allergies_____
B. Do you have daily symptoms? _____
C. Do you have seasonal symptoms? _____
D. Are you having more allergy problems recently? _____
E. What time of the year are your allergies worse? (Please list months.)_____
_____
F. What time of day or night is the worst time according to you? _____
_____
G. Does any particular exposure (cat, dust, smoke) make you much worse? (Please List.)_____
_____

H. Do you cough when you laugh? _____
I. Please list all food allergies. _____
_____
_____
J. Have you had a life threatening allergic reaction to a stinging insect (Bee, Wasp, Yellow jacket, Hornet, Fire ant)?
_____
_____
K. Have you had hives previously? _____
L. Have you had eczema previously? _____
M. How is your sense of smell? _____

III. HIVES (RASH) - complete this section if you are being evaluated for a rash.

1. When did your rash first start?_____
_____
2. Have you ever had a rash in the past?_____When?_____
_____
3. Describe the circumstances surrounding your first episode of rash. What do you think caused your rash?
_____
_____
4. How often are you having rash now?_____
5. Is your rash getting worse and occurring more often?_____
6. When you break out in rash, how long does an individual lesion persist?_____
_____
7. Where on your body to do the rash break out more often?_____
_____
8. What sizes are the individual rash lesions?_____
9. Is there any pattern or cycle that your rash follow?_____
10. What time of day do your rash usually get worse?_____
11. What is the longest period of time that you have been free of rash?_____
_____
12. Have you identified any place where your rash are worse? If yes, check:
_____indoors _____at home _____at school _____while away on vacation
_____outdoors _____at work _____the same at all locations _____ other_____
13. Are your symptoms worse in any particular season or month(s)? (Yes) (No)
When?_____
14. Does your rash itch?_____ Burn?_____Painful?____Is the rash present before you scratch?_____
or, does the hive/rash occur only after scratching?_____Is there a residual scar or pigment?_____
15. Do you get rash from lightly stroking your skin?_____
16. Does your rash occur where pressure is constantly applied to your skin, such as under your belt, etc.?_____
_____
17. Does the urticaria/rash consistently appear on your hands, feet, or buttocks?_____
18. What medications have you used to control your rash?

Antihistamines:

(1)_____ Effective / Not Effective

(2)_____ Effective / Not Effective

(3)_____ Effective / Not Effective

Steroids:_____ Effective / Not Effective

Other:_____ Effective / Not Effective

19. Do any of the following factors cause your rash to start or to worsen?

_____aspirin _____alcohol _____cold _____water

_____hot baths _____heat _____exercise _____emotional upset

_____sunlight _____ sweating _____exertion _____excitement

_____vibration _____ heavy objects or tight-fitting clothing

20. Do you have any of the following symptoms associated with your rash?

_____excessive sweating _____diarrhea _____headache

_____abdominal cramps _____faintness _____listlessness

_____frequent fever _____muscle pains _____ joint swelling

_____loss of weight _____ joint pains _____ joint stiffness

21. Do you have any respiratory allergies, such as hay fever or asthma?_____
_____

22. Do your rash appear at the same time that you have respiratory allergy symptoms of hay fever or asthma?
_____

23. Do you know of any household or work exposures that you think may cause your rash?_____
_____

24. Are you allergic to insect venoms or bites?_____
25. Have you traveled outside of the United States recently?_____
26. Are you allergic to any medications or drugs, prescribed or over-the-counter?_____
_____

27. Have you ever had rash during or just after a course of antibiotics or xray dyes?_____
_____

28. Are your rash worse after meals or any particular foods?_____
_____

29. Have you eliminated any foods from your diet which reduced your hive/rash problem?_____
_____

30. Does anything in particular that you come in contact with make your skin itch?_____
31. Are your rash worse before or during your menstrual period?_____
32. Do you or have you recently used TIDE detergent? (circle) yes no

III. ENVIROMENTAL HISTORY

A. Do your symptoms occur around any specific environment, exposure, location, or activity (for example, lawn mowing, animals, dusty environments, old leaves, strong odors, exercise)? _____
_____

B. Do you suspect that anything in your home, work place, or other locations cause your symptoms? _____
_____

C. What type of home do you have and what is the surrounding area like (suburbs, country)? _____
_____

D. Do you have indoor animals or bird? Please list. _____

E. Do you have a feather, foam, or Dacron pillow? _____

F. Do you have a new or old mattress? _____ Or, a waterbed?_____Type ?_____

G. Do you have carpeting in your bedroom? _____

H. Are your windows opened or closed most of the time? _____

I. Do you have central air conditioning? _____

J. Does air conditioning help your symptoms? _____

K. Do your symptoms become better or worse on vacations, trips, or at the beach? Please explain:
_____

L. Do you have symptoms after eating at home or in a restaurant? _____

M.Does a change in the weather influence your allergic symptoms? _____

N. Do strong odors, powders, fumes, cigarette smoke make you worse? _____

O. How do strenuous activities affect your symptoms? _____

IV. PREVIOUS ALLERGY EVALUATION AND TREATMENT

A. Name of allergist, city and date of evaluation_____
B. Please list your allergies_____
_____
C. Have you received allergy shots?_____
Were allergy shots beneficial?_____
How long were you on allergy shots (and when)?_____
D. Do you perform environmental control measures at home?_____

V. DRUG ALLERGIES

Please list name of drug, type of reaction, and approximate date.

_____
_____
_____
_____

VI. MEDICATIONS (please list either CURRENT or PAST)

Antihistamines for allergies (Benadryl, Claritin, Clarinex, Zyrtec, Xyzal, Allegra, Doxepin, Astelin):
Improved____ not improved_____ sedation_____

Bronchodilators for asthma - theophylline (Theo-Dur, Slo-Bid, Uniphyl); inhaled bronchodilators (Ventolin HFA, Proventil HFA, Maxair, ProAir, Serevent, Foradil):
_____
How often do you use?_____
Improved____ not improved_____adverse reactions_____

Corticosteroids for hay fever or asthma - oral (prednisone); intranasal sprays (Nasacort AQ, Nasonex, Nasarel, Rhinocort aqua, Flonase, Veramyst, Omnaris, Generic Fluticasone); intrabronchial (Flovent, Pulmicort, Asmanex, Azmacort, Qvar, Advair, Symbicort):
_____
How often do you use? _____
Improved____ not improved____ adverse reactions____

Antibiotics for infections (sinusitia, bronchitis):
Name_____ how often do you use? _____
Improved____ not improved____ adverse reactions (rash)_____
_____

OTHER/ CURRENT TREATMENTS (Please list all medications that you take, **prescribed** and over-the-counter, include aspirin, laxatives, sleeping medication, etc.): _____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

VII. PAST MEDICAL HISTORY

A. **Please list** all-important **surgical operations** and **other significant hospitalizations** that you have had, **even** if **they** are **unrelated to** your **allergy** problem. _____
_____

B. Have you been hospitalized for asthma? _____
When? _____

C. Do you have any current medical problems or a history of any medical problems?
Diabetes____ Thyroid disorder____ High blood pressure____ Seizures ____ Arthritis____ Hepatitis____
Ulcers____Other_____

D. Have you experienced recurrent sore throats, repeated sinus infections, or severe infections, such as pneumonia? _____

E. Have you had nasal polyps, adverse reaction to aspirin, or sinus surgery? _____

F. Do you have any other symptoms or complaints (lack of energy, anxiety, or depression)? _____

G. Have you had a chest x-ray, sinus x-ray, lung function tests, EKG, blood tests? Please comment on the results.
_____
_____

H. Are your vaccinations up to date? _____ Tetanus? (Every 10 years)____

I. Do you receive the flu vaccine yearly? _____

J. Have you received the Pneumovax (for pneumonia)? _____

VII. FAMILY HISTORY

A. Are there any members of the immediate family who have asthma, hay fever, eczema, hives, food allergies, drug allergies, insect allergies, arthritis, and recurring and/or frequent infections? **Please list** and **comment.**
_____
_____
_____

B. Are there any hereditary diseases or other disorders that seem to occur frequently in your family (diabetes, emphysema, heart problems)?_____
_____
_____

VIII. PERSONAL AND SOCIAL HISTORY

A. Do you presently smoke (how much and how long)? _____
B. Have you ever smoked and when did you quit? _____
C. How much alcohol do you drink? _____
D. Do you use recreational drugs? (This is confidential.)_____
E. What is (or was if retired) your occupation? _____
F. Are you exposed to any toxic chemicals, noxious substances, or cigarette smoke? _____
G. How long have you lived in this area _____ and Florida? _____
H. Where have you lived previously? _____
I. Are you happy with your life? _____ If not, why? _____
J. How many other people live in your home? _____ Do any of them smoke? _____

IX. PATIENT'S COMMENTS CONCERNING THEIR ALLERGIES:

REVIEW OF SYSTEMS

Do you have any of the following? (Check)

General
_____weight loss
_____chills
_____fevers
_____loss of appetite
_____dry mouth

Eyes and Ears
_____dry eyes
_____change in vision
_____trouble hearing
_____ringing in the ears

Skin
_____skin rashes
_____recurrent skin infections

Gastrointestinal
_____nausea
_____vomiting
_____diarrhea
_____change in bowel habits
_____trouble swallowing
_____heartburn

Cardiovascular
_____chest pain
_____chest pain with exercise
_____calf pain with exercise
_____ankle swelling

Kidney
_____trouble starting urine
_____bed wetting
_____burning with urination
_____loss of urine with cough or sneeze
_____frequent urination during the night

Blood
_____had anemia
_____bleed or bruise easily
_____swollen lymph nodes

Musculoskeletal
_____morning joint stiffness and aching
_____painful, swollen joints
_____muscle tenderness or pain
_____muscle weakness

Endocrine
_____cold intolerance
_____heat intolerance
_____increased thirst
_____frequent urination

Gynecological
_____excess bleeding
_____vaginal discharge
_____change in menstrual cycle

Neurological
_____weakness/ clumsiness
_____tingling, burning, or numbness of extremities

Psychological
_____fearful, anxious
_____excessive worry
_____crying spells
_____trouble sleeping
_____behavior problems

Other
_____lumps or bumps under arms, breasts
_____skin rashes in the groin
_____skin rashes between legs
_____skin rashes on the toes
_____skin rashes on the feet