

**DO NOT MAIL  
PLEASE HAND CARRY**

PATIENT ALLERGY SURVEY SHEET

NAME \_\_\_\_\_ DATE \_\_\_\_\_ AGE \_\_\_\_\_

REFERRING PHYSICIAN \_\_\_\_\_ PHONE NUMBER \_\_\_\_\_

TO WHOM DO YOU WISH A CONSULTATION LETTER SENT? (Include your doctor's address) \_\_\_\_\_  
\_\_\_\_\_

Please fill in blanks and circle other applicable answers. Feel free to make additional comments. Base your answers on your own observations and not on what you have been told by others or what you may know about previous skin test results. Though these questions are rather detailed, the information provided will be of major assistance to the doctor.

DESCRIBE YOUR MAJOR ALLERGY PROBLEM IN YOUR OWN WORDS: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

DO YOU RELATE THIS PROBLEM TO ANYTHING IN YOUR ENVIRONMENT? FOR EXAMPLE, IS IT MADE WORSE BY POLLENS (GRASS, WEEDS), MOLDS, OR FOODS? IS IT WORSE AT HOME OR AWAY, OR AT WORK, OR WITH CERTAIN HOBBIES, OR EXERCISE?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

WHEN DID THIS ALLERGY PROBLEM BEGIN? \_\_\_\_\_

WHERE WERE YOU LIVING AT THE TIME? \_\_\_\_\_

HAVE YOU SEEN OTHER SPECIALISTS ABOUT THIS PROBLEM?                      Yes                      No

IF YES, YOU SHOULD MAKE AN ATTEMPT TO HAVE RECORDS FORWARDED TO THE ALLERGY CLINIC.

I.     PAST MEDICAL PROBLEMS:

CHILDHOOD ILLNESSES: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

PREVIOUS SURGERY:

<u>OPERATION</u>	<u>YEAR</u>	<u>PLACE</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

AS A CHILD, DID YOU HAVE?	ECZEMA	Yes	No
	ASTHMA	Yes	No
	HIVES	Yes	No
	HAY FEVER	Yes	No
	FOOD ALLERGY	Yes	No

II     FAMILY HEALTH

	<u>AGE*</u>	<u>ILLNESSES**</u>
Mother	_____	_____
Father	_____	_____
Brother	_____	_____
Brother	_____	_____
Brother	_____	_____
Sister	_____	_____
Sister	_____	_____
Sister	_____	_____
Other	_____	_____

	<u>AGE*</u>	<u>ILLNESSES**</u>
Children M F	_____	_____
M F	_____	_____
M F	_____	_____
M F	_____	_____

\*AGE: CURRENT AGE OR AGE AT EXPIRATION (Circle if deceased).

\*\* ILLNESSES: IN ADDITION TO ALLERGIC DISEASE (ASTHMA, HAYFEVER, ECZEMA, FOOD ALLERGIES), LIST OTHER DISEASES SUCH AS HIGH BLOOD PRESSURE, DIABETES, CANCER, ULCER, ETC.

II. OCCUPATIONAL HISTORY:

WHAT IS YOUR CURRENT OCCUPATION? \_\_\_\_\_

EMPLOYER: \_\_\_\_\_

HOW LONG HAVE YOU WORKED AT YOUR CURRENT JOB? \_\_\_\_\_

DESCRIBE YOUR CURRENT WORK CONDITIONS IN AS MUCH DETAIL AS POSSIBLE (VENTILATION, FUMES OR DUST, EXACT JOB DESCRIPTION: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

ARE YOU EXPOSED TO:			<u>NAMES IF POSSIBLE</u>
CHEMICALS	YES	NO	_____
WOOD DUSTS	YES	NO	_____
PLASTIC FUMES	YES	NO	_____
ROCK DUSTS	YES	NO	_____
ANIMALS	YES	NO	_____
MOLDY HAY	YES	NO	_____
FLOUR	YES	NO	_____
EPOXY	YES	NO	_____
ASBESTOS	YES	NO	_____

OTHER: \_\_\_\_\_

OTHER: \_\_\_\_\_

IV: PLACES OF EMPLOYMENT PRIOR TO CURRENT JOB

<u>DATES</u>	<u>EMPLOYER</u>	<u>JOB</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

HAVE YOU EVER BEEN (OR ARE YOU NOW) DISABLED DUE TO A WORK INJURY?

Yes

No

(Details) \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

V. SOCIAL HISTORY

A. GENERAL

EDUCATION (Highest Level/Major/Degree (s)) \_\_\_\_\_

BIRTHDAY \_\_\_\_\_ PLACE OF BIRTH \_\_\_\_\_

ARE YOU MARRIED? \_\_\_\_\_ DATE: \_\_\_\_\_

PRIOR MARRIAGES? \_\_\_\_\_

SPOUSE'S OCCUPATION? \_\_\_\_\_

WERE YOU EVER IN THE ARMED SERVICES? Yes \_\_\_\_\_ No \_\_\_\_\_

TRAVEL OUTSIDE U.S.A. IN THE PAST 12 MONTHS? \_\_\_\_\_

B. HABITS:

DO YOU (OR HAVE YOU EVER) SMOKED? Yes No

IF YES, ANSWER BELOW:

SMOKE: Cigarettes – Cigar – Pipe (Circle)

STARTED SMOKING AT WHAT AGE? \_\_\_\_\_

BRAND OF CIGARETTE \_\_\_\_\_ Filter / nonfilter

TOTAL NUMBER OF YEARS THAT YOU SMOKED: \_\_\_\_\_

AVERAGE NUMBER OF CIGARETTES (OR PACKS) SMOKED PER DAY  
 DURING THE TIME THAT YOU HAVE SMOKED (OR THAT YOU SMOKED PRIOR  
 TO QUITTING): \_\_\_\_\_

HAVE YOU QUIT SMOKING? \_\_\_\_\_ IF SO, WHEN? \_\_\_\_\_

DOES ANYONE IN YOUR HOUSEHOLD SMOKE? Yes No

IF YES, WHO: \_\_\_\_\_

DO YOU DRINK ALCOHOLIC BEVERAGES? Yes No

IF YES, ANSWER BELOW: BEER WINE LIQUOR

I DRINK:

Amount of each \_\_\_\_\_ cans/week \_\_\_\_\_ glasses/week \_\_\_\_\_ ounces/week

DO YOU USE ANY PRESCRIPTION MEDICINE REGULARLY? Yes No

IF YES, PLEASE LIST: \_\_\_\_\_

DO YOU USE ANY NON-PRESCRIPTION MEDICINE (e.g. NOSE SPRAYS OR DROPS, ASPIRIN, VITAMINS, TONICS)? Yes No

IF YES, PLEASE LIST: \_\_\_\_\_

DO YOU (OR HAVE YOU EVER) USED PLEASURE OR RECREATIONAL DRUGS (e.g. POT, COCAINE, LSD, AMPHETAMINES)? Yes No

IF YES, DESCRIBE EXPOSURE: \_\_\_\_\_

AVERAGE HOURS OF SLEEP: \_\_\_\_\_ Hrs/day

DO YOU EXERCISE REGULARLY? Yes No

IF YES, DESCRIBE: \_\_\_\_\_

C. HOBBIES:

PLEASE CIRCLE YOUR HOBBIES. STAR (\*) ANY WHICH SEEM TO AGGRAVATE YOUR SYMPTOMS.

BIRD STUDY

BOWLING

CAMPING

COOKING

COIN COLLECTING

FISHING

GARDENING

GOLFING

HIKING

HUNTING

KNITTING

MOVIES/T.V.

PAINTING (WATERCOLOR, OILS, ENAMEL)

PHOTOGRAPHY

READING

SEWING

SCULPTURE

STAMP COLLECTING

STAINED GLASS

WELDING

WOOD WORKING

OTHER \_\_\_\_\_

D. DRUGS:

DO YOU HAVE ANY DRUG ALLERGIES? Yes No

HAVE YOU EVER HAD AN ALLERGIC OR TOXIC REACTION TO ANY OF THE FOLLOWING DRUGS?

ASPIRIN	Yes	No	ERYTHROMYCIN	Yes	No
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NOSE DROPS	Yes	No	OTHER ANTIBIOTICS	Yes	No
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LAXATIVES	Yes	No	HORMONES	Yes	No
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SEDATIVES	Yes	No	ANTITOXINS	Yes	No
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TONICS	Yes	No	ANTI-HISTAMINES	Yes	No
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NERVE MEDICINES	Yes	No	CORTISONE-LIKE		
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VITAMINS	Yes	No	STEROID DRUGS	Yes	No
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SULFA DRUGS	Yes	No	OTHERS	_____	
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PENICILLIN	Yes	No			
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DO YOU EVER USE ASPIRIN OR DRUGS CONTAINING ASPIRIN (e.g. BUFFERIN, CORICIDEN, 4-WAY COLD TABLETS, MIDOL, ANACIN, NYQUIL, ETC. Yes No

IF YES, HOW MANY TABLETS PER MONTH? \_\_\_\_\_

E. FOODS:

DO ANY FOODS MAKE YOUR SYMPTOMS WORSE? Yes No

IF YES, PLEASE NAME THEM: \_\_\_\_\_

SYMPTOMS PRODUCED: \_\_\_\_\_

HAVE ANY SPECIAL DIETS BEEN TRIED IN THE PAST? Yes No

IF YES, TYPE OF DIET: \_\_\_\_\_

WERE THE RESULTS GOOD? \_\_\_\_\_

F. PSYCHOLOGICAL FACTORS:

HOW WOULD YOU DESCRIBE YOURSELF (Circle all appropriate adjectives which reflect your behavior).

CALM	MOODY	NERVOUS	BAD TEMPERED
WELL ADJUSTED	DEPRESSED	ANXIOUS	IMPATIENT
OUTGOING	MOROSE	TENSE	FEARFUL

G. HOME:

<u>LOCATION OF HOME?</u>	<u>TYPE OF HOUSE?</u>	<u>HEATING SYSTEM?</u>
COUNTRY	FRAME	HOT AIR ELECTRIC
SUBURBAN	BRICK	HOT WATER GAS
CITY	MOBILE/TRAILER	STEAM PROPANE
	APARTMENT	WOOD STOVE OIL
		SPACE HEATER

HUMIDIFIER IN HOME? Yes No

AIR FILTRATION SYSTEM? Yes No

AIR CONDITIONER? Yes No

APPROXIMATE AGE OF HOUSE? \_\_\_\_\_ YEARS

HOW LONG HAVE YOU LIVED IN THE HOUSE? \_\_\_\_\_ YEARS

HAVE YOU HAD RECENT INSULATION Yes No

TYPE: \_\_\_\_\_

DO YOU HAVE	CARPETING	Yes	No
	DRAPERY	Yes	No
	FEATHER MATTRESS	Yes	No
	FEATHER PILLOW	Yes	No
	FEATHER COMFORTER	Yes	No
	UPHOLSTERED FURNITURE	Yes	No
	STUFFED TOY ANIMALS	Yes	No
	LIVING PLANTS	Yes	No
	WALL HANGINGS	Yes	No
	CAT LITER BOX	Yes	No
	DAMP BASEMENT	Yes	No

DO YOU HAVE PETS? If so, how many? \_\_\_\_\_ CATS \_\_\_\_\_ DOGS  
 \_\_\_\_\_ BIRDS \_\_\_\_\_ GERBILS \_\_\_\_\_ HORSES \_\_\_\_\_ HAMSTERS  
 OTHERS: \_\_\_\_\_

ARE YOUR PETS EVER IN YOUR BEDROOM? Yes No

IS YOUR HOME NEAR: Stables Dairies Barns Animals Factories ( Please Circle)

H. FACTORS PRECIPITATING SYMPTOMS: (Please circle any that you feel make your symptoms worse)

ALLERGENS

GRASS	WET LEAVES	ANIMAL DANDER (CAT, DOG)
WEEDS	BARN DUST	EATING CHEESE
TREES	HOUSE DUST	EATING MUSHROOMS
HAY	DAMP PLACES	DRINKING WINE
FLOWERS	COTTON LINT	DRINKING BEER

INFECTION

DO YOUR SYMPTOMS GET WORSE WITH HEAD OR CHEST COLDS? Yes No  
 DO YOUR SYMPTOMS FLARE WITH SINUS INFECTIONS? Yes No

EXERCISE

DO YOUR SYMPTOMS GET WORSE WITH EXERTION OR EXERCISE? Yes No  
 WHAT TYPES OF EXERTION ARE WORSE FOR YOU? \_\_\_\_\_

PHYSICAL AGENTS

DO YOU HAVE WORSE SYMPTOMS AFTER EXPOSURE TO THE FOLLOWING?

HEAT	Yes No	WEATHER CHANGES	Yes No
COLD	Yes No	DAMPNESS	Yes No
FIELD BURNING	Yes No	AIR CONDITIONING	Yes No
DRAFTS	Yes No	POLLUTION/SMOG	Yes No
SUNLIGHT	Yes No	VOLCANIC ASH	Yes No

MISCELLANEOUS

DO YOU HAVE WORSE SYMPTOMS AFTER EXPOSURE TO THE FOLLOWING?

COSMETICS	Yes No	TOOTHPASTE	Yes No
PERFUMES	Yes No	INSECTICIDES	Yes No
WAVE SETS	Yes No	PAINT, VARNISH FUME	Yes No
CHEMICALS	Yes No	CLOTHING STORES	Yes No
HOUSEHOLD CLEANERS	Yes No	WOOL/COTTON LINT	Yes No
MOUTHWASH	Yes No	FOOD COOKING ODORS	Yes No
NEWSPAPER	Yes No		

RASHES FROM CONTACTANTS

HAVE YOU EVER HAD A REPETITIVE RASH FROM THE FOLLOWING?  
IF YES, DESCRIBE TYPE OF MATERIAL.

- POISON IVY YES / NEVER \_\_\_\_\_
- POISON SUMAC YES / NEVER \_\_\_\_\_
- POISON OAK YES / NEVER \_\_\_\_\_
- RASHES FROM OTHER PLANTS YES / NEVER \_\_\_\_\_
- RASHES FROM WORK YES / NEVER \_\_\_\_\_
- RASHES FROM OINTMENTS YES / NEVER \_\_\_\_\_
- RASHES FROM COSMETICS YES / NEVER \_\_\_\_\_
- RASHES FROM CLOTHING YES / NEVER \_\_\_\_\_
- RASHES FROM METALS YES / NEVER \_\_\_\_\_
- RASHES FROM HOBBIES YES / NEVER \_\_\_\_\_
- RASHES FROM HOUSEHOLD AGENTS YES / NEVER \_\_\_\_\_

INSECT STINGS

HAVE YOU EVER HAD AN UNUSUAL REACTION FROM AN INSECT STING OR BITE? Yes No

TYPE OF INSECT: \_\_\_\_\_

TYPE OF REACTION: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

IS THERE ANY OTHER PERTINENT INFORMATION ABOUT EXPOSURE TO ENVIRONMENTAL ALLERGENS THAT YOU CAN GIVE US? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Have you had significant medical problems with any of the following organ systems?

If you have, **please circle them**, and then feel free to provide any additional information in the space below. Thank you.

**Skin** – skin cancer, eczema, psoriasis, hives, swelling of the skin

**Eyes** – glaucoma, cataracts, allergic eye symptoms, including itchy, watery, or red eyes

**Ears** – decreased hearing, tumors, ear fullness, ear infection

**Nose** – nasal congestion, runny nose, nasal pain, sinus pain, sinus infection, history of nasal trauma, history of surgery of the nose, tonsils, adenoids, or sinuses

**Mouth** – chronic sore throats, oral cancer, hoarseness, chronic throat clearing

**Neck** – swollen glands, thyroid problems, thyroid cancer, swollen thyroid, swollen windpipe or larynx

**Chest** – Shortness of breath, wheezing, coughing, chest tightness, chest pain or pressure, night time cough, coughing up blood, shortness of breath with exercise, waking up short of breath at night

**Heart** – history of heart disease or heart attack, fast heart beat, extra or skipped heart beats, history of abnormal heart rhythm (such as supraventricular tachycardia (SVT), ventricular tachycardia (VT), atrial fibrillation, Wolf-Parkinson-White syndrome, history of angina, history of heart surgery, cardiac bypass surgery, heart valve replacement, history of high blood pressure, history of low blood pressure

**Digestive system** – history of heartburn, gastroesophageal reflux, acid reflux, acid taste in the mouth, food sticking in the throat or chest area after swallowing, history of cancer of the stomach, bowel, or colon, bleeding in stool or with bowel movements, constipation, diarrhea

**Genitourinary system** – history of bladder or kidney infections, kidney stones, prostate problems, frequent urination, having to get up to go to the bathroom more than once per night, history of bladder or kidney surgery, chronic kidney disease, dialysis, kidney transplantation, history of kidney stones

**Neurologic** – history of seizures, currently taking seizure medicines, neuropathy, history of head trauma involving loss of consciousness, brain tumor, migraine headaches

**Bone and joint** – history of arthritis, chronic analgesic use (such as aspirin, motrin, advil, ibuprofen, etc.), muscle aches, joint aches

Additional details if needed:

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Thank you for helping us to care for you by providing this additional information.

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PATIENT SIGNATURE