ENT Allergy Associates
Allergy, Asthma & Immunology
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Allergy Survey/ Medical History—Adult

Appointment Date: _____

Name: _____ Date of birth: _____ Age: ____

Home Address: _____ Phone: _____

Referring Doctor: _____ Primary Care Doctor: _____

Circle the allergy problems that you have:

(1) Hay fever/Sinus
(2) Asthma/Bronchitis
(3) Hive/Swelling
(4) Eczema
(5) Drug Allergy
(6) Food Allergy
(7) Insect Allergy
(8) Cough
(9) Headache
(10) Immune system
(11) Other: _____
_____

1. CLINICAL HISTORY

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

   B. What are your expectations from this allergy consultation?
   _____
   _____
   _____

2. SYMPTOMS (CHECK)

Eyes	Ears	Nose	Throat	Chest	Skin
___ Itching	___ Itching	___ Sneezing	___ Itching	___ Cough	___ Rash
___ Swelling	___ Fullness	___ Itching	___ Soreness	___ Sputum	___ Eczema
___ Burning	___ Popping	___ Runny	___ Post-Nasal Drip	Color: _____ Amount: _____	___ Hives
___ Tearing	___ ↓ Hearing	___ Mouth breathing	___ Throat clearing		___ Swelling
___ Discharge	___ Pain	___ ↓ smell/ taste	___ Swelling		Where? _____
		___ discolored discharge			
		___ Nasal obstruction			

3. Allergy History

Age when your allergies started	_____	
Are you having allergy problems recently?	____ Yes	____No
Do you have daily symptoms?	____ Yes	____ No
If yes, what time of day or night is worse? _____		
Do you have seasonal Symptoms?	____ Yes	____ No
If yes, what time of year is worse (months) _____		
Have you had a life-threatening allergic reaction to an insect?	____ Yes	____ No
If Yes, what insect? _____		
Have you had hives?	____ Yes	____ No
Have you had eczema?	____ Yes	____ No
List any exposure that makes your symptoms worse (for example, cat/ dog, smoke, dust)	_____	
List any known food allergies	_____	
List any known drug allergies	_____	
Have you ever received Allergy shots?	____ Yes	____ No
If yes Age when started? _____		
How long were you on them? _____		
List your allergies	_____	
Were the allergy shots beneficial?	____ Yes	____ No
Name of allergist/ doctor and where?	_____	

4. MEDICINES—ALLERGY (please check what you have used)

Pills
___ Allegra
___ Claritin (Loratadine)
___ Clarinex
___ Pericatin
___ Vistaril (Hydroxyzine)
___ Xyzal
___ Zyrtec (cetirizine)
___ Benadryl
___ Chlor-Trimeton
___ Dimetapp Allergy
___ Tavist
___ Tylenol Allergy
___ Singulair
___ Other: _____

Eye Drops
___ Elestat
___ Optivar
___ Pataday
___ Patanol
___ Alamast
___ Alocril
___ Alomide
___ Crolom
___ Clear Eyes
___ Naphcon-A
___ Visine Allergy
___ Zaditor
___ Other: _____

Nose Sprays
___ Flonase (Fluticasone)
___ Nasacort
___ Nasalide (Flunisolde)
___ Nasarel
___ Nasonex
___ Omnaris
___ Rhinocort
___ Veramyst Astelin
___ Astepro
___ Patanase
___ Afrin
___Mucinex Nasal Spray
___ Vicks Sinex
___ Other: _____

5. MEDICINES—ASTHMA (please check what you have used)

Inhaled

Quick-Acting	Long-Acting	Steroid	Combination	Other
___ Albuterol	___ Foradil	___ Aerobid	___ Advair Diskus	___ Intal
___ Alupent	___ Serevent	___ Alvesco	___ Advair HFA	___ Tilade
___ Breathaire		___ Asmanex	___ Symbicort	_____
___ Maxair		___ Azmacort		_____
___ Primatene Mist		___ Flovent		_____
___ ProAir		___ Pulmicort		
___ Proventil		___ Qvar		
___ Tomolate				
___ Ventolin				
___Xopenex				

Pills	Injected
___ Accolate	___ Xolair
___ Singulair	___ Other: _____
___ Zyflo	
___ Theophylline	
___ Steroids	
___ Other: _____	

6. PAST MEDICAL HISTORY

A. Hospitalizations/ Operations

Reason? When? Where

B. Do you have, or have you had, any other medical problems?

____ Diabetes ____ Thyroid disorder ____ High Blood Pressure ____ Seizures
____ Glaucoma ____ Kidney ____ Arthritis ____ Hepatitis
____ Ulcers ____ recurrent sore throats ____ repeated sinus infections ____ pneumonia
____ Meningitis ____ Nasal Polyps
____ Other: _____

C. Have you had an adverse reaction to aspirin ___ Yes ___ No

D. Have you had an adverse reaction to latex product? ___ Yes ___ No

Please describe: _____

E. Have you had any of the following:

___ Chest X-ray ___ CT sinus ___ Sinus X-ray
___ Lung function Test ___ EKG ___ Blood test
Please comment on the results:
_____
_____

F. Do you receive the Flu vaccine yearly? ____ Yes ____ No

G. Have you received the Pneumovax (for pneumonia) ____ Yes ____ No

7. Current Medications—please list all medications you are currently taking (or attach list)

8. ENVIROMENTAL HISTORY

A. Do any of these environments/ activities trigger allergy/ asthma symptoms
___ Lawn mowing ___ animals ___ dusty environments ___strong odors
___Exercise ___ other: _____

B. Type of home: ___ House ____ Mobile Home ____ Apartment

C. Surrounding area: ___ City ____ Suburbs ____ Country

D. Do you have indoor animals? ___Yes List: _____
Outdoor animals? ___ Yes List: _____

E. Does your home have any of the following?
___ Carpet, where _____ ___ Humidifier ___ Air purifier ___ Ceiling fans
___ Fire Place

F. Does travel to other locations improve symptoms? ____ yes ____ No

G. Does change in the weather influence your symptoms? ____ yes ____ No

H. Does eating in restaurants influence your symptoms? ____ yes ____ No

I. Do strong odors influence your symptoms: ____ yes ____ No
(Perfumes, fumes, cigarette smoke)

9. PERSONAL AND SOCIAL HISTORY

Do you smoke? ___ Yes ___ No
If yes: How much? _____ How long? _____
Have you ever smoked ___ Yes ___ No
If yes: How much? _____ How Long: _____ When did you Quit? _____
Do you Drink alcohol? ___ Yes ___ No
If yes: How often
Do you use recreational drugs? ___ Yes ___ No
What is your Occupation? _____
Are you exposed to any toxic chemicals, noxious substances, or cigarette smoke? ___ Yes ___ No
How long have you lived in Abilene and/ or Texas? _____
Where have you lived previously? _____
How many other people live in your home: _____
Do any of them smoke? ___ Yes ___ No

10. FAMILY HISTORY—Please check all that apply

	Mother	Father	Brother/ Sister	Son/ daughter
Asthma				
Hay fever				
Eczema				
Hives				
Food allergies				
Drug allergies				
Insect allergies				
Recurring/ frequent infections				
Other significant disorders (list)				