Allentown Asthma & Allergy

ALLERGY HISTORY

Instructions: Carefully complete in full. Please print all answers. Relate all answers to your own experiences, not previous advise. this form must be completed prior to seeing the physician. "All information will be considered confidential".

Name: _____ Age: _____ D.O.B. _____

Referring Physician _____ Telephone # _____ Family Physician _____ Telephone # _____

The reason(s) for your visit: _____

ALLERGY PROBLEMS

PROBLEMS	Have you ever had the following problems?					Circle Months Symptoms Are Present:
	severity mild/med/sev	worse night	worse day	miss school or work	worse with exercise	
asthma (wheeze)						J F M A M J J A S O N D
shortness of breath						J F M A M J J A S O N D
coughing						J F M A M J J A S O N D
sinus problem						J F M A M J J A S O N D
runny or stuffy nose						J F M A M J J A S O N D
sneezing						J F M A M J J A S O N D
itchy eyes						J F M A M J J A S O N D
frequent colds						J F M A M J J A S O N D
ear infections						J F M A M J J A S O N D
rash or eczema						J F M A M J J A S O N D
hives						J F M A M J J A S O N D
other:						J F M A M J J A S O N D

FOOD REACTIONS

FOOD	can you eat this food?		rash / hives	cramps / gas	vomiting	diarrhea	constipation	nasal symptoms	chest symptoms
	yes	no							
	yes	no							
	yes	no							
	yes	no							
	yes	no							
	yes	no							

DRUG REACTIONS

DRUG	can you take this drug?		rash / hives	diarrhea	stomach upset	chest symptoms	other
	yes	no					
	yes	no					
	yes	no					
	yes	no					
	yes	no					

ENVIRONMENTAL HISTORY FORM

Please answer the questions on this form as accurately and completely as possible.
Your responses will help us determine what your symptoms are caused by.

HOME (General)

1. What kind of home do you live in?

☐House ☐ Condominium ☐ Apartment ☐Townhouse

2. Approximately how old is your residence? _____

3. How long have you lived at your current address? _____

4. Where did you live before (city/part of city)? _____

5. Is anything near your home that could pollute your air or water? ☐ Yes ☐No

If so, please describe: _____

6. Has your home ever had water damage? ☐ Yes ☐ No

If yes, please describe the type of damage and what, if anything, has been done to repair it: _____

7. How moist is the air in your home? ☐ Dry ☐ Damp ☐ Very Damp

8. Is there mildew in your home? ☐ Yes ☐ No

If yes, where is it? ☐ Inside ☐ Outside ☐ Both

9. What type of flooring do you have in the basement or lower level?

☐ Concrete ☐ Carpet ☐ Wood ☐ Dirt ☐ Other _____

10. What type of flooring do you have in the family/TV room? _____

11. Is the recreational area on the lower level? ☐ Yes ☐ No

12. Any air filtration systems in your home? ☐ Yes ☐ No

If yes, what type?

☐ Electrostatic ☐ High-efficiency particulate air (HEPA)

☐ Other _____

13. What type of heating do you have?

☐Oil ☐Gas ☐Electric ☐ Forced Air ☐Wood

☐ Hot Water ☐ Other _____

14. Do you have air-conditioning? ☐ Yes ☐ No

If yes, what type and where? _____

15. Do you have a humidifier? ☐ Yes ☐ No

16. How often do you change the heater and air-conditioner filters?

_____

17. Do you have any animals at home? ☐ Yes ☐ No

If so, what type? ☐ Cat ☐Dog ☐Rabbit

☐ Guinea pig, hampster, or other rodent ☐ Horse

Other (please list) _____

Where do these animals live? ☐ Indoors ☐ Outdoors ☐ Both

What, if any, pets did you have previously? _____

18. Have you ever had roach exposure in your home, dorm, apartment?

☐ Yes ☐ No

HOME (Bedroom)

19. Do you share a bedroom? ☐ Yes ☐ No

If yes, with whom? _____

20. What kind of bed do you sleep on?

☐ Air Matress ☐ Water bed ☐ Horsehair matress

☐ Futon ☐ Stuffed Matress ☐ Box-spring matress

21. Is the bed at least 2 feet off the floor? ☐ Yes ☐ No

22. How old is your bedding? _____

23. How many pillows do you sleep with? _____

What kind? ☐ Foam ☐ Feather ☐ Polyester or other synthetic

24. Do you have plastic covers for your bedding? ☐ Yes ☐ No

If so, where? ☐ Matress ☐ Pillow(s) ☐Both

25. Do you sleep with a comforter? ☐Yes ☐ No

If yes, what kind? ☐ Feather ☐ Cotton ☐ Synthetic

26. Is there carpeting in the bedroom? ☐ Yes ☐ No

If yes, what kind? ☐Wool ☐ Sisal ☐Synthetic

☐ High Pile ☐ Low Pile

27. How old is the carpeting? _____ Padding? _____

What kind of padding is used? ☐Foam ☐ Rubber ☐ Wool ☐ Hair

☐ Other _____

28. Does the bedroom contain any of the following?

☐ Upholstered Furniture ☐ Stuffed Animals ☐ Knickknacks

☐ Plants in Wicker Baskets ☐ Plants ☐ Books

29. Do you sleep with any stuffed animals? ☐ Yes ☐ No

30. Do you have drapes or curtains on the bedroom windows?

☐ Yes ☐No

If yes, what kind? ☐ Cotton ☐ Wool ☐Synthetic

31. Do you have venetian blinds? ☐ Yes ☐ No

32. Do you usually keep your bedroom window open? ☐ Yes ☐No

When? ☐ Day ☐ Night ☐Both

33. Do your indoor pets sleep in your bedroom or on the bed?

☐Yes ☐ No

If yes, how often? ☐ Frequently ☐ Sometimes

OCCUPATION / LEISURE

33. What do you do for a living? _____

34. What types of chemicals, fumes, or other potential pollutants are you exposed to at work or in your hobbies? _____

35. Are you exposed to animals at work? ☐ Yes ☐ No

What type, and what type of contact do you have with them?

_____

What else should we know about you? _____

_____

_____

MEDICAL HISTORY

Current Medications (include dosages): _____

_____

Previous Allergy Workup: ☐ Yes ☐ No Allergy Injections ☐ Yes ☐ No Did they help? ☐ Yes ☐ No
If yes, number of years _____

Smoke & Alcohol: Have you ever smoked ☐ Yes ☐ No packs / day _____ When did you stop? _____
Are you exposed to smoke at work? ☐ Yes ☐ No

Consume Alcohol? ☐ Occasionaly ☐ Socially ☐ Daily Type & Amount: ☐Beer ☐ Wine ☐ Liquor

Females (only): LMP _____ Could you be pregnant? ☐ Yes ☐ No Do you take BCP ☐ Yes ☐ No

OTHER MEDICAL PROBLEMS:

Have you ever had any of the following? Answer all items:

Please check	Yes	No		Yes	No
Frequent Headaches	☐	☐	Pneumonia, number past year _____	☐	☐
Frequent Nosebleeds	☐	☐	Coughed Up Blood	☐	☐
Nasal Polyps	☐	☐	Tuberculosis	☐	☐
Operation on Sinuses	☐	☐	Chest X-Rays	☐	☐
Sinus X-Rays	☐	☐	Heart Trouble	☐	☐
Ear Infections	☐	☐	High Blood Pressure	☐	☐
number past year _____			Colic or Spitting Up as an Infant	☐	☐
Hearing Problems	☐	☐	Frequent Heartburn	☐	☐
Glaucoma	☐	☐	Diabetes	☐	☐
Tonsils / Adenoids	☐	☐	Bedwetting	☐	☐
Removed (date) _____			Poison Ivy	☐	☐
Kidney or Bladder Trouble	☐	☐	Poison Oak	☐	☐
Liver Trouble	☐	☐	Other _____	☐	☐
(e.g. Hepatitis)	☐	☐			
Frequent Diarrhea	☐	☐			
Sexual Problems	☐	☐			

IMMUNIZATIONS: (list dates and reactions if any)

Polio _____ Measels _____
DPT _____ Rubella (German Measels) _____
Tetanus Booster _____ Influenza _____
Other (Pneumo-vax) _____

_____

HOSPITALIZATIONS / SURGERY:

List Most Recent First	Reason	Date
1.		
2.		
3.		
4.		
5.		