**PATIENT ALLERGY HISTORY FOR DR. A. MASTROSIMONE**

**Name**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date**:\_\_\_\_\_\_\_\_

**Age:\_\_\_\_\_\_\_\_\_\_\_**

**Main reason or symptoms for allergy consultation**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**How long have you had your symptoms?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Which symptoms bother you the most? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Circle all that apply:** My symptoms are worse in the

 Morning Evening Spring Most of summer Fall Winter

 Come and go all year Not really sure

Indoors Outdoors Around Pets dogs / cats Musty or Dusty areas

.**Are your symptoms becoming worse each year?** Yes No About the same

**List any medication or treatment that have helped**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Were you ever tested for allergies?**  Yes No

**How long ago? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Please check, if you can recall, what you were allergic to:**

**Pollen\_\_\_\_ Trees\_\_\_\_\_ Grass\_\_\_\_\_ Dust or dust mite\_\_\_\_\_ Mold\_\_\_\_ Dog\_\_\_ Cat\_\_\_**

**Any foods? (List) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

-2-

**Were you ever on allergy injections? Yes\_\_\_\_\_ No\_\_\_\_**

**How long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

***Circle any of the following symptoms you have NOW or have had in the past.***

**EYES:** itch redness tearing swelling

**Do Eye Symptoms Appear:** All year More in Spring Summer Fall

 **NOSE:** **How long have you had nasal symptoms?**\_\_\_\_\_\_\_\_\_\_

***(check all that apply)***

 Congestion/Stuffy nose\_\_\_\_\_\_\_\_Runny nose\_\_\_\_\_\_

1. Daily\_\_\_\_
2. Almost everyday\_\_\_\_\_
3. Morning\_\_\_\_
4. Evening\_\_\_\_
5. Indoors\_\_\_\_\_
6. Outdoors\_\_\_\_\_
7. Spring\_\_\_\_
8. Fall\_\_\_\_\_\_
9. Winter \_\_\_\_\_\_
10. Seasonal Changes \_\_\_\_\_\_\_
11. Snoring\_\_\_\_\_\_
12. Drippy\_\_\_\_\_\_
13. Sneezing\_\_\_\_\_
14. Nosebleeds\_\_\_\_\_\_\_\_

**-3-**

**My nasal congestion improves or is relieved by (Check all that apply):**

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

2. Decongestants(Sudafed)\_\_\_\_\_\_\_\_\_

3. Nasal steroids like Flonase\_\_\_\_\_\_\_\_\_

4. Over the counter sprays like Afrin/Neosynephrine \_\_\_\_\_\_\_\_\_\_\_\_\_

5. Nothing really helps that much.\_\_\_\_\_\_\_\_\_\_\_

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

**Sinus Problems**

**Do you have recurring sinus symptoms?** Yes No

**How long have you had sinus problems?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**How often do your sinus symptoms bother you?**

1. Daily\_\_\_\_\_\_
2. Few times a week\_\_\_\_\_\_\_\_
3. Times per month\_\_\_\_\_\_\_\_\_
4. Comes and goes all year \_\_\_\_\_\_\_\_
5. More Frequent in: Winter\_\_\_\_\_\_ Spring\_\_\_\_\_ Fall\_\_\_\_\_\_\_\_

**Where is the pressure or pain located?**

1. above the eyes\_\_\_\_\_\_\_\_\_\_
2. bridge of nose\_\_\_\_\_\_\_\_\_\_
3. cheek areas\_\_\_\_\_\_\_\_\_\_\_\_
4. back of head\_\_\_\_\_\_\_\_\_\_\_
5. top of head\_\_\_\_\_\_\_\_\_\_\_\_\_

-4-

**Do you become nauseous or vomit with your headaches?**

1. Yes\_\_\_\_\_\_\_
2. No\_\_\_\_\_\_\_\_

**What do you take to relieve your sinus headaches/pressure? \_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Are antibiotics ever prescribed for your sinus problems?** Yes\_\_\_\_ No\_\_\_\_\_\_

**If yes, how many times a year are antibiotics prescribed? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Any sinus surgeries?**  Yes\_\_\_\_\_\_ No\_\_\_\_\_\_\_\_\_

**When?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**If Yes, did surgery help?**  Yes\_\_\_\_\_\_\_\_ No\_\_\_\_\_\_\_\_\_\_\_

**EARS:** feel blocked or full\_\_\_\_\_ pressure\_\_\_\_\_ infections\_\_\_\_\_ dizziness\_\_\_\_\_\_\_

**THROAT**:

1. postnasal drip or mucus in the throat \_\_\_\_\_\_\_\_
2. hoarseness \_\_\_\_\_\_\_\_\_\_
3. frequent throat clearing \_\_\_\_\_\_\_\_\_\_
4. sore throats \_\_\_\_\_\_\_\_\_\_\_
5. swelling of the throat \_\_\_\_\_\_\_\_\_\_\_\_\_

-5-

**COUGH:** (Circle all that apply)

**How long have you had a cough**? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do you smoke? Yes No**

**Is your cough getting** - Worse About the Same Getting Better

 **Cough:(check)**

1. Mostly a Dry Cough\_\_\_\_\_\_\_
2. Is associated with or feels like mucus in my throat triggers coughing\_\_\_\_\_
3. Bring up mucus that is clear or cloudy\_\_\_\_\_

**Do you wheeze or have shortness of breath with the cough?** Yes No

**Coughing** (check all that applies):

1. occurs throughout the day\_\_\_\_\_\_\_\_\_
2. worse in the morning\_\_\_\_\_\_\_
3. worse at night \_\_\_\_\_\_\_\_\_\_\_\_\_
4. worse with exercise\_\_\_\_\_\_\_\_\_\_
5. keeps me awake \_\_\_\_\_\_\_\_ sometimes\_\_\_\_\_\_\_\_ No\_\_\_\_\_\_\_\_\_\_\_

**Do any of the following trigger your cough?**

1. Dust\_\_\_\_\_\_\_
2. Foods\_\_\_\_\_\_
3. Pets\_\_\_\_\_\_\_\_
4. Exercise\_\_\_\_\_\_
5. Other\_\_\_\_\_\_\_

**-6-**

**Were you ever diagnosed as having Asthma?** Yes No

**When? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Do you use asthma medication?** Yes No

**Do you use inhalers for asthma or for your cough?** Yes No

**If YES which ones?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Approximately how many school or work days are lost as a result of your illness?\_\_\_\_\_\_\_\_\_\_ / Yr Week Month**

**How often do you awake because of Asthma Wheezing Shortness of breath?**

**Times / week\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Month\_\_\_\_\_\_\_\_\_ Year\_\_\_\_\_\_\_\_\_**

**Almost never\_\_\_\_\_\_\_**

**List all medications you have taken or currently take for Asthma.**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Do your current asthma medications relieve your symptoms? Yes No Partially**

**Were you ever hospitalized or seen in the emergency room because of asthma symptoms? Yes No**

**When? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**-7-**

**Please list all of your current medications:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Please List Drug or Food Allergies?**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Do you have any of the following?**

1. **Diabetes\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
2. **High Blood Pressure\_\_\_\_\_\_\_\_\_**
3. **Blood disorders\_\_\_\_\_\_\_\_\_\_\_\_\_**
4. **History of heart attack or stroke \_\_\_\_\_\_\_\_\_\_\_**
5. **Hospitalizations for asthma or respiratory illness\_\_\_\_\_\_\_\_\_\_**

**-8-**

**HOME ENVIRONMENT**

How old is your home or apartment? \_\_\_\_\_\_\_\_\_\_\_\_\_

If you have a basement is it damp or moldy? Yes\_\_\_\_\_ No\_\_\_\_\_\_\_\_

If you have carpeting in the bedroom - how old is it? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How old is your mattress? \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are there (circle) dogs cats in the home? How many? \_\_\_\_\_\_\_\_\_\_

Do they sleep in the bedroom? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Additional comments you would like to mention that were not covered in the questionnaire.

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

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

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

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

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

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

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

**Home Address**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Telephone** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_