

Allergy Health Assessment

Patient Name: _____ DOB: _____

Were you referred by another doctor: Yes No Doctors Name: _____

Please check all recurrent symptoms:

Nasal Symptoms

- Runny nose
- Nasal congestion
- Sneezing
- Itchy eyes
- Watery eyes
- Itchy nose
- Itchy ears
- Itchy throat
- Decreased taste or smell

Sinus Symptoms

- Post nasal drainage
- Frequent throat clearing
- Sinus pressure
- Headache
- Colored nasal mucous
- Stuffy ears
- Frequent sinus infections
- Bad breath
- Snoring

Chest/Throat Symptoms

- Wheezing
- Chest tightness
- Shortness of breath
- Cough
- Wheezing with exercise
- Difficulty breathing at night
- Frequent pneumonia
- Throat tightness
- Hoarse voice

Skin Symptoms

- Itching
- Eczema
- Hives
- Swelling
- Blisters
- Contact allergy
- Other _____
- _____

How long have you had these symptoms?

Nasal _____ Sinus _____ Chest _____ Skin _____

How often do the symptoms occur? (constant, daily, weekly, monthly, off-and-on)

Nasal _____ Sinus _____ Chest _____ Skin _____

Is there any seasonal variation in your symptoms and if so, when are they worse? Yes No

Nasal _____ Sinus _____ Chest _____ Skin _____

What medications have you tried for your allergy symptoms? Circle the ones that have helped.

Your Environment

What environmental triggers have made your symptoms worse?

- Mowed grass Windy weather Dust Spending time outdoors Moldy places Sweeping or dusting
- Cigarette smoke Pollen Insect sting Exercise Respiratory infections Weather changes Laughing
- Cold air Nighttime Stressful events Animals (specify) _____
- Perfumes, cosmetics, odors, etc. (specify) _____

How long have you lived in this area? _____ Where else have you lived? _____

Are you better or worse in this area? Better Worse

Do you have any pets? Yes No Please list: _____

Are symptoms worse when around your pet? Yes No Any previous pets in the home? Yes No

Any smokers in the home? Yes No Type of Home: Apartment/Condo House

Has your home had water or flood damage? Yes No

ALLERScripts

The Prescription For Allergy Testing & Treatment

What kind of work do you do? _____ Are symptoms worse at work? Yes No

Have you travelled out of the country in the past year? Yes No Where? _____

Are there other households you visit frequently? Yes No Explain: _____

Family members with allergies/asthma? Mother Father Siblings

Please list all current medications including inhalers, over the counter medications, vitamins, and supplements:

Any medications that you do not tolerate? Yes No If yes, list the medications and the reaction they caused:

Any foods that you do not tolerate? Yes No If yes, list the foods and the reaction they caused:

Medical History (check all that apply)

- Cataracts High blood pressure Acid reflux Stroke Glaucoma Coronary artery disease Irritable bowel
 Migraine headaches Hearing loss Irregular heart beat Inflammatory bowel disease Seizure disorder
 Frequent nose bleeds Enlarged heart Diabetes Kidney disease Nasal polyps Lung disease Thyroid disorder
 Cancer Eartubes Sleep apnea Pituitary disorder Arthritis Osteoporosis Other _____

Previous Allergy Treatment

Other doctors seen for allergies: ENT Allergist Pulmonologist Dermatologist Gastroenterologist

Have you had nasal or sinus surgery? Yes No When and what were the results? _____

Have you been treated in urgent care or ER with asthma? Yes No Last Visit Date? _____

Have you had allergy tests? Yes No When and where? _____

Have you had allergy shots? Yes No When and where? _____

Social History

Do you now or have you ever smoked? Yes No How much & how long? _____

Is there anything else you would like to share regarding your allergies?

If you could fix one thing about your allergies, what would it be?

Office Use Only - Physician Assessment For Allergy

Rule Out Contraindications:

- Patients with poorly/uncontrolled asthma and reduced lung function
- Patients on Beta Blockers as this may inhibit the management of anaphylaxis
- Recent clinical history of anaphylaxis reaction to minute amounts of allergen
- Patients with advanced cardiovascular disease (Coronary Artery Disease and arrhythmias)
- For non-IgE-mediated asthma or rhinitis
- Patient is less than 5 years of age with inhalant therapy

Patient is taking a Beta-blocker? Yes No

Patient's chief complaint: _____

Patient demonstrates symptoms of the following conditions: _____

Notes: _____

Allergy skin testing is appropriate for this patient. Yes No

Physician's Signature: _____ **Date:** _____