# *Swedish Otolaryngology*

## ALLERGY HISTORY

**Patient Name:**_____**Date**___/____/____

**Physician Name:**_____

***Check Conditions Affecting Symptoms***

**1. During which months do symptoms occur?**

□ All months

| | | | |
|---|---|---|---|
| □ January | □ April | □ July | □ October |
| □ February | □ May | □ August | □ November |
| □ March | □ June | □ September | □ December |

**2. Are symptoms worse?**

| | | | |
|---|---|---|---|
| □ Morning | □ Afternoon | □ Evening | □ Night |
| □ At home | □ At work/school | □ Other, location_____ | |

**3. Are symptoms:**

□ Constant □ Erratic □ Rare

**4. Do symptoms interfere with your activities**

□ Not at all □ A little □ moderately □ All the time

**5. Family history:**

| | | | |
|---|---|---|---|
| □ Asthma | □ Eczema | □ Sinus problems | □ Migraine |
| □ Hay fever | □ Ulcer | □ Nervous disorder | □ Colitis |

□ Other_____

**6. Your medical conditions**

| | | | |
|---|---|---|---|
| □ High blood pressure | □ Heart disease | □ Asthma | □ Bronchitis |
| □ Bee sting allergy | □ Thyroid disease | □ Emphysema | □ Diabetes |
| □ Hormonal difficulty | □ GI disease/problems | □ | |

□ Drug Allergy, specify_____

□ Food allergy; specify_____

**7. Do any of the following cause or make your symptoms worse?**

| | | | |
|---|---|---|---|
| □ Milk or milk products | □ Fruit or juices | □ Vegetables | □ Eggs/egg products |
| □ Beer | □ Wine | □ Wheat products | □ Liquors |
| □ nuts/beans/seeds | □ Cheese | □ Meat | □ Mushrooms |
| □ Vinegar | □ Chicken | □ Poultry | □ Fish |

□ Other_____ □ Other_____

□ Other_____ □ Other_____

**8. Are your symptoms made worse by:**

| | | | |
|---|---|---|---|
| □ Wind | □ Smoke | □ Barns/Hay | □ High pollution day |
| □ Damp areas | □ Soap | □ Powder | □ Mowing lawns |
| □ Insecticides | □ Dust | □ Paint fumes | □ Perfumes |
| □ Cosmetics | □ Newspapers | □ Wool | □ House plants |
| □ Weather changes | □ Wet weather | □ Dry weather | □ Hot days |
| □ Cold day | □ Air-conditioning | □ Travel/vacations | |

□ Indoors, explain_____

□ Outdoors, explain_____

**9. Do you have pets or are you exposed to other animals?**

□ Cats □ Dogs □ Other_____

_____

***Previous Allergy Treatment***

**1. Have you ever been treated with allergy shots?**

□ Yes □ no

if yes, what were you treated for?

| | | |
|---|---|---|
| □ Grass pollens | □ Molds | □ Weed pollens |
| □ Tree pollens | □ Animals | □ Dust |

2. Did the allergy shots help you?

□ Yes □ No □ Don't know

3. What years were the shots taken?

_____to_____

***Other Information***

Please note below any other information you would like to add, or feel is relevant.

_____
_____
_____
_____
_____
_____
_____

**Patient Signature**_____**Date**___/____/____