PULMONARY ALLERGY CRITICAL CARE & SLEEP ASSOCIATES

M. WAEL AL-AMERI, M.D., F.C.C.P.
ROBERT O. GO, M.D., F.C.C.P.
MUHAMMAD KASHLAN, M.D., F.C.C.P., F.A.A.S.M.
MAZEN SABBAQ, M.D.
AHMAD GHABSHA, M.D., F.C.C.P.
EMAD SHEHADA, M.D., F.C.C.P.
AMMAR GHANEM, M.D., F.C.C.P., D.A.B.S.M.
FADI ALKHANKAN, M.D., F.C.C.P.
TINA ABRAHAM, D.O.

ALLERGY HISTORY

Patient Name: _____ Date: _____

CHECK CONDITIONS AFFECTING SYMPTOMS

1. During which months do symptoms occur? (Check all that apply.)

☐ January ☐ February ☐ March ☐ April
☐ May ☐ June ☐ July ☐ August
☐ September ☐ October ☐ November ☐ December

2. When and where are symptoms worst?

☐ Morning ☐ Afternoon ☐ Evening/Night
☐ At home ☐ At work/school ☐ Other location: _____

3. How regular are your symptoms?

☐ Constant ☐ Occasional ☐ Rare

4. How often do your symptoms interfere with your activities?

☐ Never ☐ Occasionally ☐ Half of the time
☐ Most of the time ☐ All of the time

5. Which of the following are present in your immediate family (parents, siblings, children)?

☐ Asthma ☐ Eczema ☐ Sinus problems ☐ Migraine
☐ Hay fever ☐ Ulcer ☐ Nervous disorder ☐ Colitis
☐ Other: _____

6. Which of the following conditions have you experienced? (Check all that apply.)

☐ High blood pressure ☐ Heart disease ☐ Asthma ☐ Bronchitis
☐ Hay fever ☐ Bee sting allergy ☐ Thyroid disease ☐ Emphysema
☐ Hives ☐ Hormonal difficulty ☐ Chronic sinus disease ☐ Diabetes
☐ Stomach or intestinal problems/disease
☐ Drug allergy, specify: _____
☐ Food allergy, specify: _____

7. Have you ever had an anaphylactic reaction?

☐ Yes ☐ No

If yes, what caused the reaction? (List all.) _____

_____

_____

8. Which of the following cause or make your symptoms worse? (Check all that apply.)

☐ Milk or milk products	☐ Fruit or fruit juices	☐ Vegetables	☐ Egg/egg products
☐ Beer	☐ Wine	☐ Wheat products	☐ Liquors
☐ Nuts/beans/seeds	☐ Cheese	☐ Meat	☐ Mushrooms
☐ Vinegars	☐ Chicken	☐ Poultry	☐ Fish
☐ Other: _____		☐ Other: _____	
☐ Other: _____		☐ Other: _____	

9. Which of the following cause or make your symptoms worse? (Check all that apply.)

☐ Wind	☐ Smoke	☐ Barns/hay	☐ High pollution
☐ Damp areas	☐ Soap	☐ Powder	☐ Mowing lawn
☐ Insecticides	☐ Dust	☐ Paint	☐ Fumes
☐ Perfumes	☐ Cosmetics	☐ Newspapers	☐ Wool
☐ House plants	☐ Weather change	☐ Wet weather	☐ Dry weather
☐ Hot day	☐ Cold day	☐ Air conditioning	☐ Travel/Vacations
☐ Indoors, explain: _____			
☐ Outdoors, explain: _____			

10. Which of the following animals are you exposed to in your home, work, or other environment?

☐ Cats	☐ Dogs	☐ Birds
☐ Other: _____		
_____		

PREVIOUS ALLERGY TREATMENT

1. Have you ever been treated with allergy immunotherapy?

☐ Yes ☐ No If yes, what type of allergy immunotherapy?

☐ Subcutaneous (injections) ☐ Sublingual (under the tongue)

If yes, what were you treated for?

☐ Grass pollens	☐ Molds	☐ Weed Pollens	☐ Dust
☐ Tree Pollens	☐ Animals	☐ Other: _____	

2. Did allergy immunotherapy help you?

☐ Yes ☐ No ☐ Don't Know

3. When did you receive allergy immunotherapy and for how long? From ____/____ to ____/____
MM YY MM YY

OTHER INFORMATION

Please provide any other information you would like to add.

_____

_____

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