Allergy History Survey

Name ______________________________ **Date** ______________

Occupation ______________________________ **Age** ______________

COMPLAINTS:

Please circle the appropriate number 1-5 according to severity: 1 = mild, 5 = very severe, 0 = no problem

Symptom							Symptom						
Nasal discharge	0	1	2	3	4	5	Chronic fatigue	0	1	2	3	4	5
Nasal obstruction	0	1	2	3	4	5	Food intolerance	0	1	2	3	4	5
Watery or itchy eyes	0	1	2	3	4	5	Frequent sinus or ear infection	0	1	2	3	4	5
Sneezing	0	1	2	3	4	5	Frequent colds or sore throats	0	1	2	3	4	5
Wheezing	0	1	2	3	4	5	Learning disability	0	1	2	3	4	5
Cough	0	1	2	3	4	5	Poor memory or concentration	0	1	2	3	4	5
Itching	0	1	2	3	4	5	Hyperactivity	0	1	2	3	4	5
Eczema	0	1	2	3	4	5	Abdominal gas or cramping	0	1	2	3	4	5
Hives	0	1	2	3	4	5	Arthritis or muscle aching	0	1	2	3	4	5
Headache	0	1	2	3	4	5	Asthma	0	1	2	3	4	5

Other symptoms ______________________________

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Which (if any) foods cause you any problems? ______________________________

In what year did your allergies start? ______________________________

How many months of the year do you have allergies? ______________________________

Have you been allergy tested before? ____________ If yes, did you receive desensitization shots? ______________________________

What prescription medications have you tried for allergies? How long did you use them?

1. ______________________________ For how long? ______________

2. ______________________________ For how long? ______________

3. ______________________________ For how long? ______________

4. ______________________________ For how long? ______________

Does any medication give you relief of symptoms? ______________________________

List any animals you have in or around the home ______________________________

Who else in your family has allergies? ______________________________

How did you hear about our office? *(Be specific. If a newspaper, please give name)*

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