Ross Dermatology

Allergy History & Symptoms Survey-optional

Patient Name: _____ Date of Birth:_____ Age: _____

Home Address: _____ City/State: _____ ____ Female ____ Male

Home Ph:_____ Mobile Ph:_____ Email: _____

COMMON SYMPTOMS:

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

Nasal Congestion	0 1 2 3 4 5	Fatigue	0 1 2 3 4 5
Watery, red, itchy eyes	0 1 2 3 4 5	Frequent sinus or ear infections	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	Trouble breathing while sleeping	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

List any other symptoms: _____

Are there any foods that cause you any problems?_____ How?_____

Do you have a history of allergies? __Yes __ No If yes, how long have you had allergies_____

What season(s) do your allergies flair up? ____ Spring ____ Summer ____Fall ____Winter ____All Year

Are your symptoms constant? ____ Yes ____No Intermittent? ____Yes ____No

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

1. _____ For how long?_____
2. _____ For how long?_____

Does any medication give you relief of your allergy symptoms? ____ Yes _____No

Comment: _____

Do you have pets at home? ____Yes ____No Kind: _____ Do they cause symptoms: _____

Are you exposed to fumes or dust at work? _____Yes ____No Comment: _____

Do you smoke? ____Yes ____No How much? _____ Smokey work environment? ____Yes ____No

Who else in your family has allergies/asthma? _____Mom ____Dad ____Sibling ____Childeren ____More Than One

Have you been diagnosed with asthma? ____Yes ____No When? _____ Severity: ____Mild ____Moderate ____High

Do you suffer from uncontrolled asthm or reduced lung fuction? ____Yes ____No

Ever had a sever allergic reaction? ____Yes ____No Name of Medication: _____

(Answering YES to any of the questions above, you will be asked to see the clinican as allergy testing may be contraindicated)

Reviewed by: _____Provider: _____ Date: _____