Lawrence L. Braud, M.D., F.A.C.S.
Jack L. Breaux, Jr., M.D., F.A.C.S.
Lynn C. Murphy, M.D., A.P.M.C.
Cheryl Braud, M.D.

Frank L. Fazio, M.D., F.A.C.S.
J. Stan Montelaro, M.D.
Benjamin F. Walton, M.D.

ALLERGY HISTORY

Patient's Name: ______________________ Date: ______________

To be filled out by patient Your answers to the following questions will help to determine the cause of your allergy symptoms. It is important to check each question as accurately as possible.

	Yes	No
Have trouble with your skin?		
Eczema		
Hives		

	Yes	No
Have trouble with your ears?		
Popping		
Itching		
Hearing loss		
Fluid in ears		
Infection / Pain		

	Yes	No
Have trouble with your throat?		
Frequently sore / drainage		
Itching throat / mouth		

	Yes	No
Have trouble with your eyes?		
Redness		
Itching		
Tearing		
Puffiness		

	Yes	No
Have trouble with your nose?		
Clear / colorless discharge		
Thick / colored discharge		
Nasal itching / rubbing		
Constant stuffiness		
Periodic stuffiness		
Sniffles		
Sneezing		
Mouth breathing or snoring		

	Yes	No
Have troubles with your chest?		
Wheezing with colds		
Wheezing when exposed to dust, pollen, animal, etc.		
Wheeze / cough after exercise		
Cough? What kind?		
Deep / or productive?		
Loose		
Constant		
Dry / tight		
Daytime		
Nighttime		

	Yes	No
Are your symptoms mild?		
Moderate		
Severe		
Present most of the time		
Present part of the time		
Present rarely		
Interfering with your life		
Preventing many normal activities		

	Yes	No
Which of the following do you think cause your symptoms or make them worse?		
Indoors		
Outdoors		
At home		
At work		
Morning		
Afternoon		
At night		
Weather change		
Dry weather		
Windy day		
Hot day		
Cold day		
Air conditioning		
In barns		
Damp areas		
Mowing lawn		
Dusty environment		
High air pollution		
Animals		
Cooking odors		
Smoke		
Soap powder		
Insecticides		
Paint fumes		
Perfumes		
Cosmetics		
Newspapers		
Wool		
Road dust		
Milk or milk products		
Eggs		
Wheat products		
Nuts, beans, or seeds		
Chocolate		
Fish		
Meat		
Fruit		
Vegetables		
Alcoholic beverages		
Cheese, mushrooms		
Beer		
Wine		
Aspirin		
Chemicals (list): ______ ______		
Drugs (list): ______ ______		

	Yes	No
During what months do you usually have symptoms?		
All months		
January		
February		
March		
April		
May		
June		
July		
August		
September		
October		
November		
December		

*Describe what symptoms bother you most

____

____

*When did your condition begin?

____

____

	Yes	No
Do you use medication regularly for nasal symptoms?		
What medication ______		
Does it help?		

	Yes	No
Do any of your blood relatives have allergies?		
Have you ever had skin tests for allergies?		
Do you have allergies?		
What are you allergic to? ______ ______ ______		

Is there anything else about your problem which you think might be important or unusual?

____

____

____

--- OVER ---

	Yes	No
Do you take medications daily or frequently?		
Aspirin		
Cortisone		
Laxatives		
Sedatives		
Birth control pills		
Vitamins		
Ointments		
Nose drops / sprays		
Hormones		
Others (list):		

	Yes	No
Smokers in your home?		
Do you smoke?		

	Yes	No
Do you spend a great deal of time in activities?		
Photography		
Carpentry		
Camping		
Sewing		
Gardening		
Painting		
Cooking		
Hobbies (list):		
Sports (list):		
Other (list):		

	Yes	No
Do you have any animals in your home?		
Dog		
Cat		
Bird		
Rodent		
Other (list):		

	Yes	No
Do you live in a House?		
Apartment?		
In the city?		
Is your dwelling: New?		
3-10 years old?		
11-15 years old?		
> 25 years old?		

	Yes	No
Do you sleep with a pillow?		
Is is Dacron?		
Is it foam rubber?		
Is it feather?		
Other (describe):		

	Yes	No
Do you use a humidifier?		
Do you have an air conditioner?		
At work		
At home		
In bedroom		
Central		

	Yes	No
Is your heating system:		
Gas		
Electric		
Other (describe):		

	Yes	No
Have you had any of the following?		
High blood pressure		
Migraine headaches		
Skin disease		
Heart Disease		
Frequent headaches		
Sinus disease		
Stomach disease		
Asthma		
Nasal polyps		
Emphysema		
Broken nose		
Overactive thyroid		
Bronchitis		
Nasal surgery		
Underactive thyroid		
Hay fever		
Deviated septum		
Hormonal difficulty		
Hives		
Food allergy		
Drug allergy (describe):		

Describe your occupation:

Are there any materials used in your occupation that you think have something to do with your condition? (describe):

	Yes	No
At work, are your symptoms better?		
Worse		
The same		