# Allergy Health History Form

**Patient Name** _____ **Date of Birth** _____ **Date** _____

**Parent/Guardian** _____ **Phone** _____

**Occupation** _____ **Height** _____ **Weight** _____

## Medical Information

**A. Chief Allergy Complaints: List each complaint**

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

**B. During which time of the year do you experience your symptoms:**

_____ Spring _____ Summer _____ Fall _____ Winter

**C. What prescription and non-prescription medications do you take?**

_____ _____ _____

_____ _____ _____

Medication Allergies: _____

**D. Circle the following medical conditions you are experiencing or have experienced in the past:**

| **Current** | | **Past** | **Current** | | **Past** |
|---|---|---|---|---|---|
| _____ | hypertension | _____ | _____ | nasal surgery | _____ |
| _____ | skin disease | _____ | _____ | nasal polyps | _____ |
| _____ | hives | _____ | _____ | headaches | _____ |
| _____ | asthma | _____ | _____ | sinus disease | _____ |
| _____ | hay fever | _____ | _____ | anaphylaxis | _____ |

**E. List physicians you have consulted in the past for your allergies:**

_____ _____

**F. Miscellaneous (indicate type)**

Dog (inside or outside)

_____

Cat (inside or outside)

_____

Birds

_____

Feather pillows (how many)

_____

House Plants (how many)

_____