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)

_____