CENTURY CITY ALLERGY
PATIENT MEDICAL HISTORY QUESTIONNAIRE (ALLERGY)

Patient Name: _____Today's Date: _____

Sex: _____ Date of birth: _____ Age: ____ Referred by: _____

Pharmacy of choice: _____ Phone#: _____

Primary Care Doctor: _____ Doctor Phone#: _____

Reason for your visit:_____

Describe the most distressing symptoms caused by your medical problem:

_____

_____

When did symptoms begin?_____ How often they occur?_____
Worse at night or day?_____How long do symptoms last? (hours, days, etc.)_____
Circle seasonal pattern: Spring Summer Fall Winter ***ALL YEAR***

What relieves symptoms or causes them to go away?_____

_____
What makes the symptoms worse?

_____
List all **medications** you have tried in the past to relief these symptoms and the response you have had to each (including over the counter medications):

Medication	Relief	No Relief	Side Effects

All current medications (including allergy medications, nutritional supplements, vitamins, herbals):

_____
_____
_____

_____

_____

Have you taken any allergy medications within the last 7 days? Yes / No

If yes, which one(s) and dosage(s): _____

Known Allergies (circle all that apply)**:**

Allergy to foods: Milk, cheese, eggs, fish, shellfish, nuts, peanuts, vegetables, melon, strawberries, wheat, rice, soy, other:_____

Allergy to: X-Ray Dye: Yes / No **Latex** (balloons, condoms…): Yes / No

Allergy to medications (which):_____

_____

Past Medical History: Do you have any pain? Yes / No **Pain Scale**: (0=none; 10=intense) ___/10

Have you ever had any: **Allergy skin test**? Yes / No **Allergy Blood Test?** Yes / No

Date of testing: _____ Physician's name: _____

Have you ever been on allergy shots? Yes / No Date(s): _____

Do you have **asthma**? Yes / No (* <= less than,** >= greater than)

Day symptoms: <* 2 times a week, >**2 times a week, every day, continuous

Night symptoms: <*2 times a month, >**2 times a month, >** 1 time a week

Do you have **frequent infections** (sinus, lungs, bacterial)? Yes / No

Have you had a sinus infection? Yes / No If yes, how often per year: _____

Have you ever had a sinus X-ray or CT? Yes / No Date(s): _____

Have you been **stung** by an insect (bee/wasp/hornet/yellow jacket)? Yes / No Reaction: _____

Do you have Skin Problems: Eczema, Hives, _____ ? Seen by a Dermatologist? Y/N

Other Medical Problems: _____

_____

History of Surgeries / Year _____

_____

Social/Environmental History:

Do you live in a house or apartment? _____ How old is the home: ___ years old

How long have you lived in Los Angeles? _____

How long have you lived in your current home? _____ Is there any obvious mold problem? Y / N

Heat: Forced hot air / Gas / Oil / Radiator / Electric Air Conditioning: Central / Window

Type of floor in your bedroom: Carpeting / Hard wood / Tile / Other: _____

Type of bedding: Comforter: down/synthetic Pillow: feather/synthetic/polyester

Pets: Dog Cat Other:_____

History of smoking: Yes / No How long? _____ Packs per day: _____

Prolonged cigarette smoke exposure ("second hand smoke"): Yes / No

Do you drink alcohol? Yes / No How often? _____ Drugs: _____

Please list anything not discussed in this questionnaire that you consider important to share with your doctor: (all responses are confidential)

_____