

Allergy History

1. List allergy symptoms:

2. When did symptoms develop? _____

3. Are symptoms seasonal? If so, which seasons? _____

4. Do you have asthma? If so, what medications do you use to control your symptoms?

5. Have you ever gone to the ER for allergies or asthma? _____

6. Have you had allergy testing in the past? If so, how long ago? _____

7. Do you own any pets? If so, what kind? _____

8. Is it OK to test both arms for intradermal injections? _____

9. Is there any possibility that you could be pregnant? _____

10. Please list any known allergies to:

Medications: _____

Food: _____

Animals: _____

Please check the situations that apply to you:

Pollen Allergy

- Aggravated outdoors
- Aggravated with wind
- Itching of the eyes
- Aggravated on clear days
- Improved in AC
- Aggravated outdoors, (7-11 AM)

Dust Allergy

- Aggravated indoors
- Increased after going to bed
- Increased with cold weather
- Nasal symptoms with little or no itching of eyes
- Aggravated by AC
- Increased with dusting

Mold Allergy

- Aggravated outdoors (4 to 8 PM)
- Increased by cool evening air
- Aggravated when mowing or playing on grass
- Aggravated from mid August to December

Please rate your symptoms on a daily basis.

(Make your selection #1 is low degree, #5 is high degree)

EYES (itchy, watery, or swelling):	1	2	3	4	5
EARS (itchy, draining, or congested):	1	2	3	4	5
NOSE (runny or congested):	1	2	3	4	5
HEADACHES (allergy related):	1	2	3	4	5
POST NASAL DRIP:	1	2	3	4	5
COUGH (allergy related):	1	2	3	4	5
SNEEZING:	1	2	3	4	5