HIGHLAND CLINIC

A Professional Medical Corporation

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ALLERGY HISTORY

Name: _____
Date of Birth: _____ **Age:** _____
Date of Visit: _____

Room No. _____

PLEASE COMPLETE PAGES 1 thru 5

Patient: Please fill out this side.

Physician Notes:

The Reasons For Coming Here Are:

Referred By: _____

CHIEF COMPLAINTS:

- ☐ Nose Allergy
- ☐ Food Allergy
- ☐ Drug Allergy
- ☐ Insect Sting Allergy
- ☐ Contact Skin Allergy
- ☐ Skin Rash
- ☐ Eczema
- ☐ Headache
- ☐ Wheezing or Asthma
- ☐ Shortness of Breath
- ☐ Cough
- ☐ Sore Throat
- ☐ Hives
- ☐ Itching
- ☐ Swelling
- ☐ Other: _____

Other Symptoms:

	YES	NO
Itchy or watery eyes	☐	☐
Snoring or breathing through the mouth	☐	☐
Drainage down the throat	☐	☐
Frequent yellow or green nasal drainage	☐	☐
Frequent infections	☐	☐
Headaches	☐	☐
Vomiting	☐	☐
Abdominal pain	☐	☐
Diarrhea	☐	☐
Bee sting reactions	☐	☐

Transfer of allergy care from Dr._____

Continuation of allergy shots started _____ years ago

Diagnosis of asthma made _____ years ago

Number of past hospitalizations for asthma:____

Number of past emergency visits for asthma:____

Days of school or work missed in past year:____

Number of ear infections in the past year:____

Number of sinus infections in the past year:____

Number of pneumonias during *lifetime*:____

Physician Notes:

Patient's Name:_____

These Symptoms Occur:

☐ Spring
☐ Summer
☐ Fall
☐ Winter
☐ Hours at a time
☐ Days at a time
☐ Weeks at a time
☐ All the time
☐ At home - room: _____
☐ Other: _____

WORSE:

☐ Outdoors ☐ At work ☐ At school
☐ All day ☐ At night ☐ In Mornings
☐ Other: _____

Physician Notes:

Symptoms Are Made Worse By:

☐ Changes in Weather
☐ Changes in Temperature
☐ Changes in Humidity
☐ Fatigue
☐ Exercise
☐ Heat
☐ Cold
☐ Mowing Grass
☐ Raking Leaves
☐ Perfumes or Scents
☐ Dusting or Vacuuming
☐ Cleaning Fumes
☐ Cigarette Smoke
☐ Cats
☐ Dogs
☐ Feathers
☐ Wool
☐ Colds
☐ Emotions - (Anger, Laughter, Crying)
☐ Foods: _____
☐ Other: _____

Physician Notes:

Current Environment: (✓ if present)

	YES	NO		YES	NO
Cats	☐	☐	Cigarette Smoke	☐	☐
Dogs	☐	☐	Forced Air Heat	☐	☐
Birds	☐	☐	Air Conditioning	☐	☐
Other Pets	☐	☐	Fans	☐	☐
Feather Pillow	☐	☐	Mold Growth	☐	☐
Feather Comforter	☐	☐	Damp Walls or Carpet	☐	☐
Carpets or Rugs	☐	☐	Houseplants	☐	☐
Air Cleaner	☐	☐	Improvement on Trips	☐	☐
Plastic Covers on Mattress, Pillows and Box Springs				☐	☐

Occupation: _____

If patient is a child, is he or she in a nursery setting? ☐ ☐

If YES, how many children are in the nursery? _____

Physician Notes:

Patient's Name: _____

Environmental History

Composition of House

☐ Foundation ☐ Pier/Beam ☐ Foundation and Pier/Beam

Type of Home: ☐ Apartment ☐ Mobile Home/Trailer ☐ Townhouse ☐ Brick ☐ Wood ☐ Brick/Wood

Age of Home? [ ]

Has there ever been any water damage in the home? ☐ Yes ☐ No [ ]

Does the house have carpet, if so how old? ☐ Yes ☐ No age of carpet [ ]

☐ Carpet removed

Heating/AC ☐ Gas Heat/Electric Air ☐ Central Heat/Air ☐ Window Units

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How old is the mattress? [ ]

What type of pillow does the patient sleep on? ☐ Feather ☐ Foam

Pets: ☐ Yes ☐ No [ ]

Do any pets sleep in the bedroom, if so where? ☐ Yes ☐ No ☐ Pet sleeps in the bed ☐ Pet sleeps on the floor
☐ Pets in cages in bedroom

Hobbies: [ ]