E·N·T of ATHENS

ALLERGY HISTORY

Date: _____ Referred by: _____

Name: _____ Date of Birth: _____

Address: _____

Home Phone: _____ Work Phone: _____

Occupation: _____ For how long? _____

Social Security #: _____

Main Complaint: _____

_____

Prior Allergy Treatment or Testing: ❑ YES ❑ NO (If yes, where and when?)_____

_____

Other Medical Problems: _____

_____

List Major Surgeries and Dates: _____

_____

List ALL medications now being taken: _____

_____

CHECK ALL SYMPTOMS YOU HAVE EXPERIENCED:

NOSE: ❑ itching ❑ sneezing ❑ nasal congestion (stuffy) ❑ runny nose ❑ post nasal discharge
❑ redness ❑ frequent "colds" ❑ polyps ❑ sinus trouble ❑ sinus infections (_____# per year)

EYES: ❑ itching outer corner ❑ itching inner corner ❑ puffiness ❑ blurred vision
❑ excessive tearing ❑ dark circles under eyes ❑ discharge ❑ visual disturbances

EARS: ❑ itching ❑ itching deep in ears ❑ tinnitus (ringing) ❑ dizziness ❑ popping
❑ fullness ❑ pressure ❑ hearing loss ❑ drainage (discharge) ❑ red
❑ frequent infections (_____ # per year)

MOUTH & THROAT: ❑ frequent sore throats ❑ itching of palate or back of throat ❑ difficulty swallowing
❑ lump sensation ❑ laryngitis ❑ need to clear mucous in the morning ❑ mouth ulcers
❑ swelling of lips ❑ swelling of tongue ❑ scratchy or burning sensation

CHEST: ❑ Cough ❑ wheezing ❑ shortness of breath ❑ pain ❑ tightness ❑ asthma
❑ frequent chest colds or infections ❑ chronic obstructive pulmonary disease (COPD)
❑ frequent attacks of bronchitis (_____ # per year)

GASTRO-INTESTINAL: ❑ belching ❑ bloating ❑ heartburn ❑ retasting of foods ❑ cramping ❑ bad breath
❑ excessive gas ❑ diarrhea ❑ constipation ❑ poor appetite ❑ irritable bowel syndrome

GENTRO-URINARY: ❑ difficulty voiding ❑ frequency ❑ urgency ❑ burning ❑ prostatitis ❑ vaginitis ❑ itching ❑ frequent urinary infections ❑ frequent yeast infections

SKIN: ❑ hives ❑ rashes ❑ eczema ❑ swelling ❑ itching ❑ reactions to cosmetics ❑ blisters or peeling of hands ❑ athlete's foot ❑ jock itch

NEUROLOGICAL: ❑ headache (❑ sinus ❑ migraine ❑ tension) ❑ decreased attention span ❑ learning disability ❑ seizures ❑ inability to concentrate ❑ poor memory

MISCELLANEOUS: ❑ joint pain ❑ muscle pain ❑ arthritis ❑ restless legs ❑ chronic fatigue ❑ insomnia

ANSWER ALL QUESTIONS BELOW WHICH PERTAIN TO YOU:

Seasonal Incidence:

Do you have trouble or is your condition worse:

1. In the Spring ❑ Yes ❑ No
2. In the Summer ❑ Yes ❑ No
3. In the Fall ❑ Yes ❑ No
4. In the Winter ❑ Yes ❑ No

Describe your allergy "attack" symptoms:

5. Do your attacks last
   - A few minutes ❑ Yes ❑ No
   - Several hours ❑ Yes ❑ No
   - Several days ❑ Yes ❑ No
   - A whole season ❑ Yes ❑ No
   - The whole year ❑ Yes ❑ No
6. Do the attacks occur regularly at a particular time of day or night? ❑ Yes ❑ No
7. Have you found anything which will relieve attacks? ❑ Yes ❑ No
8. Will the attacks cause you to lose sleep? ❑ Yes ❑ No
9. Will the attacks interrupt your daily routine? ❑ Yes ❑ No

Childhood History:

10. Did you have eczema? ❑ Yes ❑ No
11. Did you have colic? ❑ Yes ❑ No
12. Were you often sick? ❑ Yes ❑ No
13. Did you have bronchitis or asthma? ❑ Yes ❑ No
14. Did you have croup? ❑ Yes ❑ No
15. Did you have frequent attacks of "stomach ache", diarrhea or vomiting? ❑ Yes ❑ No
16. Did you have frequent colds? ❑ Yes ❑ No
17. Did you have frequent ear infections? ❑ Yes ❑ No
18. Did you have sinus trouble? ❑ Yes ❑ No
19. Did you have frequent sore throats? ❑ Yes ❑ No

Family History:

Have any members of your family (this includes mother, father, grandparents, aunts, uncles, brothers, sisters and children) had any of the following diseases:

20. Asthma ❑ Yes ❑ No
21. Hay Fever ❑ Yes ❑ No
22. Nasal allergy (frequent attacks of sneezing, runny nose, blockage of nose, post nasal drip) ❑ Yes ❑ No
23. Hives ❑ Yes ❑ No
24. Eczema ❑ Yes ❑ No
25. Chronic skin disease ❑ Yes ❑ No
26. Frequent headaches ❑ Yes ❑ No
27. Migraine ❑ Yes ❑ No

Non-pollen Inhalant History:

House Dust:

Do you notice that your trouble begins or is aggravated:

28. When the house is being cleaned or swept ❑ Yes ❑ No
29. When rugs are being cleaned ❑ Yes ❑ No
30. When the bed is being made or the mattress being turned ❑ Yes ❑ No
31. During spring house cleaning ❑ Yes ❑ No
32. When you sit on old, overstuffed furniture ❑ Yes ❑ No
33. In such dusty places as: theaters, churches, grocery stores, department stores, libraries, your bedroom ❑ Yes ❑ No

Atmospheric Mold:

Do you notice that your trouble begins or is aggravated:

34. During prolonged periods of damp or humid weather ❑ Yes ❑ No
35. When you are around where grass is being mowed or weeds are being cut ❑ Yes ❑ No
36. When you are near hay or straw (as at the circus, in a barn, around a hay stack, on a hay ride) ❑ Yes ❑ No
37. When you go into an old damp house, a damp basement, shed or cellar ❑ Yes ❑ No
38. When you enter a closet in which are stored old shoes, unused luggage, gloves or other leather goods) ❑ Yes ❑ No
39. If you eat cheese, mushrooms, cantaloupe or drink beer ❑ Yes ❑ No
40. When the first cold snap of autumn ❑ Yes ❑ No

Animals:

Do you notice that your trouble begins or is aggravated:

49. When lying on a feather pillow ❑ Yes ❑ No
50. When fluffing pillows ❑ Yes ❑ No
43. If you use a down comforter ❑ Yes ❑ No
44. If you are near chickens, ducks, geese, pigeons, parrots, turkeys, canaries or other birds ❑ Yes ❑ No
45. If you are around anyone who works around poultry or other fowl ❑ Yes ❑ No
46. Do you have pets in the house or yard? ❑ Yes ❑ No
47. When you are around any of the following animals: dogs, cats, horses, goats, rabbits, cows, hogs or sheep ❑ Yes ❑ No
48. When you handle or come into contact with any of the following: furs, rugs, certain articles of clothing, dress goods, blankets, gloves, hats, toy animals or brushes ❑ Yes ❑ No

Smoke:

Do you notice that your trouble begins or is aggravated:

49. Do you smoke? ❑ Yes ❑ No
50. When you are in night clubs or other smoky places ❑ Yes ❑ No

Orris Root:

Do you notice that your trouble begins or is aggravated:

51. When using face, talcum, body, bath or tooth powder ❑ Yes ❑ No
52. In beauty parlors or barber shops ❑ Yes ❑ No
53. When you are around people who use a lot of powder or perfume ❑ Yes ❑ No

Pyrethrum-Orris Root-Lethane-Paradichlorobenzene:

Do you notice that your trouble begins or is aggravated:

54. When you are exposed to household insect powders or sprays ❑ Yes ❑ No
55. When you are exposed to powders, sprays or crystals used for mothproofing purposes ❑ Yes ❑ No
56. When you are exposed to dusting powders or sprays used in the gardens or on crops ❑ Yes ❑ No

Food History:

57. Do you suspect any food in causing or aggravating your condition? ..... ❑ Yes ❑ No
58. Are there any foods which you dislike? ..... ❑ Yes ❑ No
59. Are there any foods in which you over-indulge or eat frequently because you like them so much? ... ❑ Yes ❑ No
60. Is there any seasonal food (for example strawberries) in which you over-indulge? ..... ❑ Yes ❑ No
61. Are there any foods you find difficult to digest? ..... ❑ Yes ❑ No
62. Do any foods you eat cause ❑ nausea, ❑ vomiting, ❑ diarrhea, ❑ heartburn, ❑ belching, ❑ gas on the stomach, ❑ cramps, ❑ hives, ❑ skin rashes, ❑ headaches? (check all those that apply) ..... ❑ Yes ❑ No
63. Are you on any type of diet at present? ..... ❑ Yes ❑ No

Physical History:

Does your trouble at times seem to begin or become aggravated

64. By change in the weather ..... ❑ Yes ❑ No
65. By exercise ..... ❑ Yes ❑ No
66. By fatigue ..... ❑ Yes ❑ No
67. By loss of sleep ..... ❑ Yes ❑ No
68. By excitement ..... ❑ Yes ❑ No
69. By emotional upheaval ..... ❑ Yes ❑ No
70. By a hot or cold bath ..... ❑ Yes ❑ No
71. By becoming overheated ..... ❑ Yes ❑ No
72. By prolonged periods of physical or mental work or prolonged stress (as when there is someone sick in the family) ..... ❑ Yes ❑ No
73. As a result of “nervousness” ..... ❑ Yes ❑ No
74. Air conditioning ..... ❑ Yes ❑ No

Focal Infection History:

75. Are you conscious of a foul odor in your nose? ..... ❑ Yes ❑ No
76. Do you have a dripping from the back of your nose into your throat which has a “sickening sweet” taste or is yellow or green like pus? ..... ❑ Yes ❑ No

Environmental Survey: (home survey)

77. Is your house old? ..... ❑ Yes ❑ No
78. Is your house new? ..... ❑ Yes ❑ No
79. Is your house damp? ..... ❑ Yes ❑ No
80. Is your house dry? ..... ❑ Yes ❑ No
81. Do things mildew easily around the house? ..... ❑ Yes ❑ No
82. Near your house, is there:
    - a factory ..... ❑ Yes ❑ No
    - a railroad ..... ❑ Yes ❑ No
    - a lake ..... ❑ Yes ❑ No
    - a poultry yard ..... ❑ Yes ❑ No
    - a swampy area ..... ❑ Yes ❑ No
    - lots of weeds ..... ❑ Yes ❑ No
    - anything you suspect as a possible cause of your symptoms ..... ❑ Yes ❑ No
83. Is your house heated by:
    - Open gas heaters ..... ❑ Yes ❑ No
    - Floor gas furnaces ..... ❑ Yes ❑ No
    - Radiators ..... ❑ Yes ❑ No
    - Open fireplaces ..... ❑ Yes ❑ No
    - Central heating system with ducts ..... ❑ Yes ❑ No
84. Is your house cooled by:
    - An attic fan ..... ❑ Yes ❑ No
    - Window air-conditioning ..... ❑ Yes ❑ No
    - Central air-conditioning ..... ❑ Yes ❑ No
    - Window fans ..... ❑ Yes ❑ No
85. Do you have plants in the house or in window planter boxes? ..... ❑ Yes ❑ No

86. Do you use insect sprays or moth repellents in the house? ❑ Yes ❑ No
87. Do you keep any books or magazines that gather dust in the house? ❑ Yes ❑ No
88. Do you have overstuffed furniture? ❑ Yes ❑ No
89. Do you use feather pillows? ❑ Yes ❑ No
90. Do you use down comforters on the bed? ❑ Yes ❑ No
91. Do you have rugs on the floor? ❑ Yes ❑ No
92. Do you use padding under your rugs? ❑ Yes ❑ No
93. Do you have draperies on the windows? ❑ Yes ❑ No
94. Do you have throw pillows around the house? ❑ Yes ❑ No
95. Are there any smells or fumes continuously or frequently present about the house? ❑ Yes ❑ No
96. Is there any place in the house where you have symptoms regularly? ❑ Yes ❑ No
97. Are the walls in your house covered with wallpaper? ❑ Yes ❑ No
98. Is there any type of business enterprise carried out in your house? ❑ Yes ❑ No
99. Are you engaged in a hobby in your house? ❑ Yes ❑ No

Work or School Survey

100. Do you have symptoms at work or school? ❑ Yes ❑ No
101. Is the place where you work or attend school: ❑ Yes ❑ No
    damp ❑ Yes ❑ No
    cooled with window or attic fans ❑ Yes ❑ No
    air-conditioned .....
    centrally heated ❑ Yes ❑ No
    dusty ❑ Yes ❑ No
    smoky ❑ Yes ❑ No
102. As far as you know, do you inhale anything at work or school which might cause or aggravate your symptoms? ❑ Yes ❑ No
103. Are there fumes, gases, smokes or odors where you work or attend school? ❑ Yes ❑ No

Activities

104. Do you take part in any outdoor sports or hobbies? ❑ Yes ❑ No
105. Are you better when you are away from home on a trip, such as vacation time? ❑ Yes ❑ No

Previous Treatment History:

106. Have you ever had any operations for your condition? ❑ Yes ❑ No
107. Have any of the treatments or drugs prescribed given prolonged relief? ❑ Yes ❑ No

GENERAL MEDICAL HISTORY

1. Do you often have pain in the face? ❑ Yes ❑ No
2. Do you often experience flushing of the face with a sensation of warmth? ❑ Yes ❑ No
3. Do you often suffer pains in the eyes: ❑ Yes ❑ No
4. Do you experience a sense of burning or dryness in the nose or sense of stuffiness, rather than actual blockage? ❑ Yes ❑ No
5. Do you often have pain inside of your nose? ❑ Yes ❑ No
6. Are you bothered with a bad odor inside your nose? ❑ Yes ❑ No
7. Do you frequently blow large, dried crusts or scabs from your nose? ❑ Yes ❑ No
8. Have you ever had severe nosebleeds? ❑ Yes ❑ No
9. Have you ever fallen or been hit hard on the nose? ❑ Yes ❑ No
10. Has your nose ever been broken? ❑ Yes ❑ No
11. Have you ever been told that you had a crooked bone in your nose? ❑ Yes ❑ No
12. Have you ever had an operation on your nose or sinuses? ❑ Yes ❑ No
13. Are you bothered by a soreness or burning in your mouth? ❑ Yes ❑ No
14. Do you have bad breath at times? ❑ Yes ❑ N
15. Are you often bothered with a sensation of dryness in your mouth? ❑ Yes ❑ No
16. Is your tongue often sore? ❑ Yes ❑ No
17. Do you often find yourself grinding your teeth or do people tell you that you grind your teeth while sleeping? ❑ Yes ❑ No
18. Do you often have pain around your ears when you chew? ❑ Yes ❑ No
19. Do the glands in your neck swell when you get sore throats?
20. Have your tonsils been removed? ❑ Yes ❑ No
21. Did you ever have to take a breathing test? ❑ Yes ❑ No
22. Do you have chronic chest trouble (except asthma)? ❑ Yes ❑ No
23. Did you ever have T.B. (tuberculosis)?
24. Do you live with anyone who has had T.B.? ❑ Yes ❑ No
25. Did you ever have a chest or lung operation? ❑ Yes ❑ No
26. Did the doctor say that you have heart trouble? ❑ Yes ❑ No
27. Do you have high blood pressure? ❑ Yes ❑ No
28. Do you have low blood pressure? ❑ Yes ❑ No
29. Do your hands and feet swell badly? ❑ Yes ❑ No
30. Do you get short of breath easy? ❑ Yes ❑ No
31. Does your heart ever beat so fast and hard that it seems to shake your chest?
32. Do you frequently get leg cramps? ❑ Yes ❑ No
33. Is your appetite poor? ❑ Yes ❑ No
34. Have you lost weight lately? ❑ Yes ❑ No
35. Do you gain weight easily? ❑ Yes ❑ No
36. Have you ever had stomach ulcers? ❑ Yes ❑ No
37. Did you ever have rheumatic fever? ❑ Yes ❑ No
38. Do you seem to get tired faster than the average person? ❑ Yes ❑ No
39. Are you sick often? ❑ Yes ❑ No
40. Did a doctor say you were anemic? ❑ Yes ❑ No