Allergy History Form
Fax to: 650-282-4497 Or
Email to: Kevin@allergik.org

PATIENT QUESTIONNAIRE

Please fill out this form completely

Patient Name_____ DOB_____

Primary Care
Physician:_____ Referred by:_____

Other family members seen in our office_____

Current Medications-(Please look at bottle or packaging as many names sound and are spelled similarly. Use a separate sheet of paper if necessary)

Medication Name	Dose	How often	Duration Taken

Other Allergy Medication Tried or used in the past	Name	Did it work? Y/N

Medication Allergies ☐ **No Known Drug Allergies**

Drug Name	Reaction	When?

Past Medical History/Problems: *(check all that apply)*

☐	Asthma	☐	Deafness	☐	Heart Murmur	☐	Tuberculosis	■	**CANCERS**
☐	Angina	☐	Depression	☐	High Blood Pressure	☐	Thyroid disease	☐	Head/Neck
☐	Anemia	☐	Diabetes	☐	Hepatitis	☐		☐	Lung
☐	Arthritis	☐	Emphysema	☐	Hemorrhoids	■	**MEN ONLY**	☐	Breast
☐	Bleeding Problems	☐	Glaucoma	☐	Kidney stones	☐	Prostate problem	☐	Stomach
☐	Broken Bone	☐	Gallstones	☐	Rheumatic Fever	■	**WOMEN ONLY**	☐	Colon
☐	Cataracts	☐	Gout	☐	Stroke	☐	Menstrual Problems	☐	Liver
☐	Chronic Bronchitis	☐	Goiter	☐	Stomach Ulcer	☐	Breast Cancer	☐	Lymphoma
☐	Cirrhosis	☐	Heart Attack	☐	Skin Problems	☐	Other GYN issues	☐	Leukemia

Personal Medical History:

Have you ever seen an allergist before? Yes ☐ No ☐ Who?_____
Have you ever had allergy skin testing? Yes ☐ No ☐ When?_____
Have you ever been given allergy shots? Yes ☐ No ☐ When?_____

Please list any surgeries you have had:_____
_____
_____

Do you smoke: Y☐N☐ If yes, how much?_____ How long?_____

Does anyone else smoke in your home? Y☐ N☐

Do you drink alcohol? Y☐N☐ If yes, how many per week? Beer Wine Liquor

Have you ever had an allergic reaction to a food? Y☐ N☐ What?_____

Have you ever had an allergic reaction to an insect bite? Y☐ N☐ When?_____

OTHER HISTORY:

Occupation: _____

Are you exposed to any chemicals or fumes at work? Y☐ N☐ What?_____

Do you have any pets in your home? Y☐ N☐ What?_____

Do you have mold or mildew in your home? Y☐ N☐

Do you have air conditioning? Y☐ N☐ Do you have a basement? Y☐ N☐

Do other family members have allergies?_____

Have you *recently* had any of the following? (Check all that apply, if in doubt, leave blank)

GENERAL
☐Fatigue
☐Weight loss
☐Weight Gain
☐Night sweats
☐Fever
☐Sleep apnea
☐Recurrent Infections

SKIN
☐Rash
☐Hives
☐Itching
☐Swelling
☐Bruising

EYES
☐Itching
☐Dryness
☐Eye pain
☐Red eyes
☐Vision Changes

NOSE
☐Bloody Nose
☐Congestion
☐Runny Nose
☐Sinus Infections
☐Polyps

EARS
☐Ear infections
☐Hearing loss
☐Ringing
☐Vertigo

MOUTH/THROAT
☐Sore Throat
☐Lip Swelling
☐Tongue Swelling
☐Throat Itching

ENDOCRINE
☐Tremor
☐Heat/Cold Intolerance

BLOOD
☐Easy Bleeding
☐Bruising

HEART/LUNGS
☐Wheezing
☐Shortness of Breath
☐Persistent cough
☐Bronchitis
☐Frequent Pneumonia
☐Palpitations
☐Chest Pain
☐Heart Murmur
☐High Blood Pressure

STOMACH/ INTESTINES
☐Heartburn
☐Nausea
☐Upset stomach
☐Vomiting
☐Abdominal Pain
☐Diarrhea
☐Constipation

GENITOURINARY
☐Urinary Tract Infections
☐Blood in Urine
☐Incontinence

OB/GYN
☐Vaginal Infections
☐Estrogen Therapy
Number of Children____

MUSCULOSKELETAL
☐Joint Pain
☐Joint Swelling
☐Muscle weakness

NEUROLOGIC/ MENTAL HEALTH
☐Headaches
☐Seizures
☐Numbness/Tingling
☐Depression
☐Nervousness
☐Anxiety