Lake Norman
Ears, Nose & Throat
Piedmont HealthCare

Allergy History Form

Patient Name: _____ Age: _____ Sex: ___ DOB: _____

1. **How long have you had allergy symptoms?** _____
2. **Have you ever been allergy tested in the past?** YES NO
3. **Is there a family history of Allergies or Asthma?** YES NO
4. **What are your allergy symptoms (circle all that apply)?**

ITCHY EYES	WATERY EYES	DARK CIRCLES UNDER EYES
CHRONIC COUGH	SORE THROAT	DIFFICULTY BREATHING
RUNNY NOSE	NASAL CONGESTION	CHRONIC SINUS INFECTIONS
POST NASAL DRIP	SNEEZING	HIVES
HEADACHES	ITCHY SKIN	RASHES

5. **Other symptoms not listed above:**
   _____
6. **General allergy questions: (Check all that apply)**

a. Where are your symptoms worse?	**b. Are your symptoms worse:**	**c. Are your symptoms worse :**	**d. When are your symptoms worse?**
_HOME	_INDOORS	_MORNING	_SPRING
_WORK	_OUTDOORS	_EVENING	_SUMMER
_SCHOOL	_BOTH	_NIGHT	_FALL
_ALL OF THE ABOVE		_AFTER MEALS	_WINTER
		_ALL OF THE ABOVE	_ALL OF THE ABOVE

7. **Do you have pets?** YES NO **What kind?** _____
8. **Did the previous owners of your home have pets?** YES NO **What kind?** _____
9. **Are you exposed horses or cows at all?** YES NO
10. **How old is your home?** _____
11. **What medications do you take?**

ASPRIN	BIRTH CONTROL	NOSE DROPS/SPRAY	LIST OTHERS:
CORTISONE	ANTIBOTICS	HORMONES	
TRANQUILIZERS	VITAMINS	ANTIHISTAMINES	
HIGH BLOOD PRESSURE	OINTMENTS	DECONGESTANTS	
THYROID MEDICATION	CHOLESTEROL MEDS		

12. **Which medications relieve your allergy symptoms?** _____
13. **How well do your allergy medication(s) relieve your symptoms?** Completely Mostly Partly
13. **Any other information that you want to list?** _____

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