ALLERGY DATA BASE & HEALTH HISTORY

Please complete the following questionnaire legibly and **COMPLETELY**. This form will become the beginning of your chart, and will help the doctor to determine the cause of your problems. **ALL ITEMS MUST BE COMPLETED.**

Patient's Name: _____ Date this form completed: _____
(LAST) (FIRST) (MIDDLE)

Referred by: _____ Date office visit: _____

Patient's Nickname: _____ Patient's personal physician: _____

Address _____ Sex _____ Age _____

_____ Date of Birth _____
(CITY) (STATE) (ZIP)

Home Phone (____) _____ Bus. Phone (____) _____ Patient Occupation _____

Mother's Occupation _____ Father's Occupation _____

Marital Status (please circle): single married divorced separated widowed

If patient is a child, marital status of parent(s): single married divorced separated widowed

Last school grade completed by patient: _____ If child, lives with: _____

Mother's Name: _____ Father's Name: _____

Name of individual responsible for bill: _____

_____
(STREET) (CITY) (STATE) (ZIP)

Employer: _____

Ins. Co. _____ If Medicare, # _____

Certificate/Policy # _____

SYMPTOMS/PROBLEMS:

Concisely list your symptoms/problems, i.e.: Why did you come to this office? What is bothering you? Explain if there is a pattern to the symptoms. Date symptoms/problems first recognized by patient. Score them 1-5. 1 = least bothersome, 5 = most bothersome.

MEDICATIONS

A. List any medications, their specific names, dosage, and how often **currently** taken. (Show brand names)

_____

_____

_____

_____

_____

_____

B. List any vitamin, mineral or nutritional supplements, their specific names, dosage, and how often **currently** taken. (Show brand names)

_____

_____

_____

_____

_____

_____

Please include copies of any laboratory results from the past two years.

Please complete all forms and return them 1 week prior to your scheduled appointment.

Do you take any of these daily or as often as 1-2 times a week?	YES	NO
Aspirin or Acetaminophen (Datril, Tylenol, etc.)		
Ibuprofen (Advil, Nuprin)		
Sinus or allergy medications		
Laxatives		
Antacids		
Nose drops/sprays		
Ointments		
Antidepressants		
Nebulizers		
Other drugs		

List any medications to which you are allergic or which cause unpleasant side effects. Please describe reaction:

Have you ever taken an oral cortisone preparation such as Prednisone, Decadron, Medrol or others?

	YES	NO	DON'T KNOW	COMMENTS
about a week				
about two weeks				
about a month				
two months or more				
Have you received cortisone type "allergy shots" such as Depo Medrol, Decadron, Kenalog, or others?				
once				
twice				
three				
four or more				
Have you ever been on birth control pills?				
yes, but less than six months				
six months to two years				
more than two years				
are you taking them now?				
any side effects?				

The approximate total amount of time that you have been on Tetracyline, Ampicillin, Keflex, Ceclor, Erythromycin, or other antibiotics (for any reason)

one month or less				
one month to six months				
six months to two years				
two years or longer				

The medical reasons for which you have taken the antibiotics listed above include (select all applicable):

Acne or other skin infection				
Kidney, bladder, prostrate, or other urinary tract infections				
Ear infections				
Tonsillitis				
Strep throat				
"Colds"				
Surgically related problems				

Have symptoms occurred in the following patterns in the past year?

	YES	NO	COMMENTS
Worse indoors			
Improved outdoors			
Increase in symptoms within 30 minutes after going to bed			
Symptoms recur or increase with return of cold weather			
Nasal symptoms with little or no itching of eyes			
Worse in air conditioning			
Symptoms increase or occur while dusting or sweeping			
Symptoms are worse outdoors 4:30-8:30 p.m.			
Symptoms increase in cooling evening air			

	YES	NO	COMMENTS
Symptoms are worse in damp places			
Nasal symptoms without eye itching while mowing grass or playing on lawn			
Worse raking leaves or playing in leaves			
Worse September to heavy (killing) frost			
Symptoms increase around October 1st			
Runny nose, sneezing, eye or nose itching			
Itching of the whole eye			
Itching of the inside corners of the eye only			
Symptoms worse on clear days			
Worse outdoors 7-11:00 a.m.			
Improved indoors, especially in air conditioning			
Flare when going from air conditioned room to open air			
Little or no symptoms when it is raining			
Worse in basements			
Symptoms are worse around feed mills			
Symptoms are worse in barns			
Symptoms are worse in certain homes			
Whose home?			
React to cats or in home with cats			
React to dogs or in home with dogs			
React to other animals			
Which?			

Do you usually have **ANY** symptoms to **ANY** degree in these months?

	YES	NO	DON'T KNOW		YES	NO	DON'T KNOW
January				July			
February				August			
March				September			
April				October			
May				November			
June				December			

What 2 consecutive months are your symptoms the least bothersome? List: _____

What 2 consecutive months are your symptoms the most bothersome? _____

If the above 2 questions cannot be answered, are your symptoms the same year round? ☐ Yes ☐ No

HOME ENVIRONMENT	YES	NO
House # years old		
Apartment		
Mobile Home		
In a wooded area		
On a farm		
Garage - attached		
detached		
breezeway		
Basement - dry		
damp		
musty		
ever flooded?		
Crawlspace		
How long have you lived in your present home?		
Have there ever been animals in the home?		
Have the pets been treated for fleas?		
Did this cause any symptoms?		

List current pets:

_____

_____

How long have they been present?

_____

_____

HOME ENVIRONMENT: (continued)	YES	NO
Please list past pets and what years they were in the home:		
Have you used moth balls/crystals?		
Did this cause any symptoms?		
Any insulation done?		
Type: fiberglass		
cellulose (ground up newspapers, blown in)		
sawdust		
styrofoam		
UFFI (ureafoam)		
formaldehyde insulation		
other		
year done		

HOME ENVIRONMENT (continued)		YES	NO
Heat delivered by:	Forced air		
	Gravity		
	Radiators		
	Electric panels		
Air Filter:	Fiberglass		
	Electronic		
	HEPA		
	Other		
Humidifier:	On furnace		
	Room unit		
Air conditioning:	Whole house		
	Room units		
Air purifier:	Brand		
	What rooms		
Smoking:	Patient (now)		
	Spouse		
	Mother		
	Father		
	Cigarette		
	Cigar		
	Pipe		
Have you stopped smoking and when?			
Have your lawn, trees or shrubs been sprayed or treated chemically?			
Any symptoms after?			

If yes, what symptoms?

		YES	NO
Type of drinking water:	Well water		
	City water		
	Other		
Type of carpet:	Synthetic		
	Wool		
	Cotton		
	Other		
	Rubber/plastic padding		
	Natural fiber padding		
Type of floors in the home:			
Hardwood			
Plywood			
Slab concrete floors			
Any room in which symptoms are worse?			

Which?

Family hobbies:

List any new furnishings:

List any rooms with new carpet:

Appliances:	Gas	Electric
Stove		
Water heater		
Clothes dryer		

Heating System:	YES	NO	
Gas			
Fuel oil			
Coal			
Electric			
Wood burning fireplace			
Wood burning stove			
Steam			
Space heater			
Type:			
Other			

BEDROOM:		YES	NO	
Mattress:	Regular			
Mattress cover:	Cotton			
	Allergy Proof			
Pillow:	Feather			
	Foam Rubber			
	Dacron			
	Other			
Covers:	Wool			
	Cotton			
	Synthetic			
	Down			
Bedroom carpeted?				
Stuffed animals?				
Does child sleep with these?				
Has your home been recently painted?				
Any recent remodeling?				

Describe:

	YES	NO
Have you been away from your home or your environment in the last several years?		
If yes - where?		
When away, were there any changes in your symptoms?		
If better to what degree?		
If walking on an ocean beach, were you symptom free?		

WORK ENVIRONMENT:	YES	NO	
At work, are your symptoms			
better			
worse			
the same			
Are you bothered by smoking in your work place?			
Any particular place or room at work which bothers you?			
Have you been exposed to any of the following items at work presently or in previous jobs?			
Asbestos			
Chemicals			
Fumes			
Mists (like spray paints)			
Biologics (blood, serum, etc.)			
Dusts (grain, cotton)			
Agricultural sprays			

	YES	NO	
Do you think your work and/or machines have anything to do with your symptoms?			
Are there materials used at work that you think have something to do with your symptoms?			
Describe these materials and/or machines/equipment			
How long at this employment?			
How many miles do you travel to work?			
by expressway miles?			
sideroad miles?			

MISCELLANEOUS:	YES	NO	
Do you suspect sensitivity to:			
Latex			
Insect Venom			

OTHER ENVIRONMENTAL QUESTIONS	YES	NO	IF YES, WHAT SYMPTOMS?
Do you notice an increase in symptoms in:			
church			
malls or shopping centers			
school			
particular classroom			
car			
gas station			
beauty parlor, hair stylist			
fabric store			
carpeting store			
hospital			
other			

Do these products bother you?	YES	NO	IF YES, WHAT SYMPTOMS?
Gasoline products			
Exhaust fumes			
Soaps, detergents			
Fabric softeners			
Bleaches			
Chlorinated water			
Ammonia			
Polishes, floor waxes			
Insect sprays			
Mosquito spray			
Moth balls			
Asphalt, tar			
Disinfectant, sprays - liquid			
Rubber products			
Varnish, paint, shellac			
Hair sprays			
Cosmetics			
Perfumes			
Newsprint			
Tobacco Smoke			
Metals			
Nickel			
Mercury			
Inexpensive earrings			
Other			

WEATHER-RELATED	YES	NO	IF YES, WHAT SYMPTOMS?
Worse with storm front			
Worse with wind (from which direction)			
Worse on rainy day			
Worse on dry day			
Other			

FOODS

Are you on any special diet at the present time:

	YES	NO	
Rotation			
Vegetarian			
Low salt			
Pritikin			
Weight Reduction			
Low Cholesterol			
Diabetic/Hypoglycemic			
Stone Age Diet			
Other			
Are you excessively sleepy after meals?			
Do you notice itching			
of the roof of the mouth?			
between the shoulder blades?			
inside the ear canal?			
and/or rash inside the bend of the elbows or behind the knees?			
of the rectum?			
of the nose?			
Do you get hives?			
Do you get canker sores?			
Have a foul breath odor?			
Are you bothered by			
belching			
gas			
stomach ache			
nausea			
vomiting			
bloating			
constipation			
diarrhea			
Do you retaste foods after you have eaten them?			
Which foods?			

Do you:	YES	NO	
Notice increased symptoms 5 to 60 minutes after meals			
Awaken from sleep between 1:00 to 5:00 a.m.			

If answer above is yes, is there any specific food you are hungry for at that time?

When sitting or standing, do you ever consciously notice that one side of your nose is blocked and the other side less so?			
And that later it is the reverse?			

Please list any foods you avoid. Explain why you avoid them.

Please list any foods you eat excessively, i.e. once daily or more often.

Which food would you miss most if taken out of your diet?

Please list alcoholic beverages you drink and how often.

CANDIDA	YES	NO
On antibiotics, frequently in past?		
How long ago?		
List any side effects (example: diarrhea)		
Frequent vaginal infections, yeast infections, or infection of the prostate gland?		
When on antibiotics, is there an increase in vaginal or prostate symptoms?		
Rectal itching?		
Frequent fungal infections of nails?		
Other fungal infections?		
Thrush?		
Ringworm?		
Jock itch?		
Athlete's foot?		
Other skin signs?		
Cracked or split nails?		

	YES	NO
Fingertips?		
Cuticles?		
Callouses?		
Do you crave sugar?		
Do you crave breads?		
Do you crave pastries?		
Do you have symptoms when you drink alcoholic beverages?		
What symptoms?		
Are you bothered by premenstrual syndrome?		

If answer to previous question is YES, how does PMS bother you?

ALLERGY TREATMENT HISTORY

	YES	NO	COMMENTS
Have you ever had allergy tests for airborne inhalants? (Please attach a copy of the test results if you received a copy.)			
Type: Intradermal (injection by needle into skin)			
Prick (the skin is just "poked")			
Scratch			
RAST (blood test)			
Other			
When: Within the last year			
1-2 years ago			
3-5 years ago			
6 or more years ago			
What doctor(s)?			
Are you taking allergy injections **now**? (Select most accurate answer and tell for how long)			
More often than once a week			
Once a week			
Every two weeks			
Monthly			
Seasonally, as needed			
How long have you been receiving allergy injections?			
Date of last dose			
Did you see improvement with the shots?			
Have you ever taken allergy injections in the **past**?			
When was the first dose?			
Do you or did you have arm reactions?			
Have you ever been tested for food allergies? (Please attach a copy of the test results if you received a copy.)			
Type: Never			
Elimination or rotary diet			
Sublingual test (under the tongue)			
Intradermal (injection with syringe)			
Prick (the skin is "poked")			
Scratch			
Patch			
RAST (blood test)			
Cytotoxic Test or ALCAT Test			
Other			
When: Within the last year			
1-2 years ago			
3-5 years ago			
6 or more years ago			
What doctor(s)?			
Type of treatment: A rotary diversified diet			
Elimination diet			
Sublingual therapy			
Shots			

	YES	NO
Can you have a good nights rest, wake up in the morning and still feel tired?		
Do you have problems with short term memory?		
Do you have greater emotional swings than what **you** think you should. [By this we mean emotional stimulation (your ups) or emotional depression (your downs).]		
Do you not tolerate the cold? i.e. (Do you need to wear more clothes than others in order to stay warm?)		
Do you think your reflexes (your neuromuscular responses) are as quick as they used to be?		
Are you gaining more weight than you think you should for your calorie intake?		

Please record your basal temperature. (What is your temperature before you get out of bed in the morning?)

Oral_____ OR Rectal_____ OR Axillary_____

If you do not know, please take your temperature.

HEALTH HISTORY

	Patient	Spouse	Mother	Father	Brothers/Sisters	PLEASE EXPLAIN SPECIFIC DIAGNOSIS
Allergies						
Asthma						
Birth defects						
Blood diseases (anemia, hemophilia, etc.)						
Bone or joint disorders						
Cancers, tumors, malignancies						
Chronic lung diseases (asthma, T.B., etc.)						
Eye or ear disorders						
Glandular diseases (thyroid, diabetes, etc.)						
Heart trouble						
Kidney or urinary disease (bladder problems, cystitis)						
Mental retardation						
Muscle disease (weakness, poor control)						
Nerve disease (epilepsy, cerebral palsy, others)						
Psychiatric condition						
Vaginal discharge, yeast infection						
Venereal disease (S.T.D.)						
HIV Positive -- AIDS						
High blood pressure						
Gastro-intestinal disorders (ulcers, diverticulitis, Crohn's disease, irritable bowel syndrome, colitis)						
Skin disorders (eczema, psoriasis, rashes)						
Liver disease (hepatitis, cirrhosis, jaundice)						
Mononucleosis						
Polio myelitis						
Coxsackie virus						
Herpes						
Migraine headaches						
Alcoholism						
Other						

Major hospitalizations: If you have ever been hospitalized for any medical illness or operation, write down your most recent hospitalizations below.

	YEAR	OPERATION OR ILLNESS	NAME OF HOSPITAL	CITY AND STATE
1st hospitalization (most recent)				
2nd hospitalization				
3rd hospitalization				

Outpatient surgery:

	YEAR	OPERATION OR ILLNESS	NAME OF HOSPITAL	CITY AND STATE
1st surgery (most recent)				
2nd surgery				
3rd surgery				

Test results:

	YES	NO	DON'T KNOW	YEAR	RESULTS
Chest X-ray					
Kidney X-ray					
G.I. series					
Colon X-ray (barium enema)					
Gallbladder X-ray					

HEALTH HISTORY (continued)

	YES	NO	DON'T KNOW	YEAR	RESULTS
EKG					
EEG					
Immunoglobulins					
Any other studies					

Past diseases:

	YES	NO	DON'T KNOW	YEAR	PROBLEMS
Chicken pox					
Mumps					
Hepatitis					
Croup					
Chronic bronchitis					

	YES	NO	DON'T KNOW	YEAR	PROBLEMS
Measles					
German measles (3 day)					
Rheumatic fever					
Whooping cough					

	YES	NO
Have you ever received a blood transfusion?		
If yes, when?		
Have you been outside the continental U.S. in the past 5 years?		
If yes, where?		

Date of last physical exam _____ Done by _____

Explain any abnormal finding(s) _____

OVERALL HEALTH REVIEW (please mark any symptoms that apply)

Please check yes to current symptoms (Those occurring within the past month). Pages 9-12

Central nervous system:

	YES	NO	COMMENTS
Headaches:			
Age onset			
Duration			
How many days per month do you have headaches?			
Do they interfere with sleep?			
Do you have to go to sleep for the headache to go away?			
Type:			
Pulsating			
Constant			
Severe			
Migraine			
Relieved by aspirin			
Relieved by other			

	YES	NO	COMMENTS
Aggravated by:			
Cigarettes			
Cold drinks			
Beer or liquor			
Food			
Frequency:			
Regular			
Periodic			
Related to menstrual cycle			
Time of year:			
Anytime			
Fall			
Spring			
Summer			
Winter			
Daytime			
Night time			
Interferes with sleep			

HEALTH HISTORY (continued)

Central Nervous System (continued):

	Yes	No	Comments
Fainting			
Depression			
Mood swings			
Hyperactivity			
Irritability			
Hallucinations			
Forgetfulness/poor memory			
Spacey feeling			
Poor concentration			
Apathy			
Confusion			
Seizures			
Jekyll & Hyde personality			
Panic Disorder			
Sleep Apnea			
Insomnia			
Nightmares			
Sleepiness			
Feeling of rage			
Learning disorders			
Numbness & tingling			
Anxiety (panic)			
Dizziness			
Listlessness			
Fatigue			
On arising			
After meals			
All the time			

Eyes

	Yes	No	Comments
Itching			
Burning			
Pain			
Tearing			
Red eyes			
Sensitive to light			
Puffy eyes			
Dark circles under			
Visual difficulties			
Other			

Ears

	Yes	No	Comments
Itching			
Full, blocked, ear pressure			
Frequent ear infections			
Recurrent fluid behind eardrums			
Reddening of ears			
Earaches			
Sensitive to sound			
Hearing loss			
Dizziness			
Other			

Nose

	Yes	No	Comments
Sneezing spells			
Itching			
Stuffy			
Runny			
Post nasal drip			
Sinusitis			
Sinus pressure/pain			
Nosebleeds			
Nasal polyps			
Rub nose upwards			
Snoring			
Other			

Throat

	Yes	No	Comments
Itching			
Sore			
Tight			
Swollen			
Difficulty swallowing			
Choking			
Hoarse voice			
Frequent clearing of throat			
Post-nasal drainage			

Mouth-teeth-gums

	Yes	No	Comments
Increased salivation			
Bad breath			
Dental problems (Explain)			
Problem with anesthetic			
T.M.J.			
Coated tongue			
Canker sores			
Gum disease			
Tongue or lip swelling			

Breathing

	Yes	No	Comments
Coughing			
Wheezing (only with infection			
Wheezing (other times)			
Chest feels tight			
Not enough air			
Rapid breathing			
Short of breath			
Sleeps with number of pillows			

Gastrointestinal

	Yes	No	Comments
Appetite			
Good			
Poor			
Selective			
Stomach aches			
Cramps			
Intestinal gas			
Inordinate hunger/thirst			
Nausea			
Vomiting			
Fullness/bloating			
Constipation			
Diarrhea			
Foul odor - stool			

Heart-Vascular

	Yes	No	Comments
Rapid or irregular pulse			
Heart murmur			
Chest pains			
Rheumatic fever			
Other heart disease			
Sweating			
Chilly feeling			
Puffy face			
Cold hands/feet			

Bruising

	Yes	No	Comments
Spontaneous			
Easily			
Often			

Blood Pressure

	Yes	No	Comments
High			
Low			

Skin

	Yes	No	Comments
Flushing			
Pallor - white			
Acne			
Dryness			
Oiliness			
Dandruff			
Athlete's foot			
Itching			
Sores, infections			
Vitiligo			
Rashes			
Describe:			
Excessive/offensive body odor			

Muscles and Joints

	Yes	No	Comments
Arthritis			
Bursitis			
Fibrositis			
Joints (aching or pain)			
Neck			
Upper back			
Lower back			
Legs			
Seasonal			
Continuous			
Swelling			
Other			
Weakness			
Shakiness			

Kidney and Bladder
Urination

	Yes	No	Comments
Painful			
Delayed			
Prolonged			
Frequency of:			
Daytime			
Night time			
Urgency			
Bed wetting			
Leaking of urine			
Frequent bladder infection			

Penile, vaginal organs

	Yes	No	Comments
Sores			
Itching			
Yeast infections			
Menstrual irregularities			
Pre-menstrual syndrome			
Impotence			
Loss of libido			
Discharge			
Describe:			

Swelling

	Yes	No	Comments
Generalized			
Hands			
Fingers			
Ankles			
Intermittent			
Continuous			

Lymph

	Yes	No	Comments
Swollen, tender glands			

Stress

	Yes	No	Comments
Home			
Mild			
Moderate			
Severe			
Work			
Mild			
Moderate			
Severe			
School			
Mild			
Moderate			
Severe			

Miscellaneous

	Yes	No	
Do you live near high tension lines?			
Do you live close to a freeway?			
Do you travel by air frequently 12 or more times a year?			
Do you exercise daily			
3 or more times a week			
Is your car less than 2 years old?			
List the primary and secondary industries of the area:			

PARENT, PLEASE FILL OUT THIS PAGE, FOR INFORMATION ON YOUR CHILD.
ADULTS, PLEASE FILL OUT THIS PAGE, FOR YOUR INFANCY, IF THE INFORMATION IS AVAILABLE TO YOU.

Patient's birth history

	YES	NO	DON'T KNOW
During the pregnancy with patient, did mother			
Have high blood pressure?			
Have diabetes or sugar in her urine?			
Have albumin or protein in her urine?			
Have a urinary infection?			
Have German (3 day) measles?			
Take medicines prescribed by her doctor?			
Frequently smoke cigarettes?			
If YES, about how many packs a day?			
Have a venereal disease such as gonorrhea or syphilis?			
Have a dependence on drugs or alcoholic beverages?			
If YES, please explain:			
Other conditions:			
How long was pregnancy?			
How early did mother start seeing the doctor?			
Did patient have hiccups while in mom's uterus?			
Was this patient premature?			
Was more than one baby born?			
Did mother have a difficult delivery?			
Was it a breech (bottom first) delivery?			
Was it a cesarean delivery?			
What was patient's weight a birth?			
Was there an Rh problem?			
Was anything wrong with patient at birth?			
If YES, what?			

Maternal and family history of patient

How many children have you (mother) had?
Which one is this child?
Have you (mother) had any premature births?
Have you (mother) had any cesarean births?
Have you (mother) had any miscarriages?
Mother's age now:
Father's age now:
Mother's height:
Father's height:
Number of people living in child's home:
Who spends most time caring for child (father, mother, etc.)?

Introduction of foods:

1) Was this patient breast or bottle fed? _____

2) Failure to gain or excessive weight gain? _____

3) If bottle fed, what formula did you use? _____

4) Did you need to switch formulas for any reason? _____

List formulas tried and reasons for changing each formula: _____

_____

_____

_____

_____

5) At what age did patient begin solid foods? _____

6) Did patient have any problems with any solid foods introduced? _____

If yes, list the foods and the problems noticed: _____

_____

7) List any foods omitted from the diet during early childhood or infancy. If omitted, why?

_____

_____

_____

_____

_____

_____

_____

_____