LAKE GROVE ENT | EAR NOSE & THROAT

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# Patient History

Patient _____ Age _____ Sex: ☐ M ☐ F

Physician _____

**FAMILY HISTORY** (Indicate members of your family who have had an allergic condition)

☐ mother ☐ brother ☐ grandparent
☐ father ☐ sister ☐ mother's
☐ father's

**PATIENT SYMPTOMS** (Indicate your major symptoms from the list below)

GENERAL BODY
☐ hives
☐ rashes
☐ aches
☐ fever
☐ tension
☐ fatigue

DIGESTIVE TRACT
☐ indigestion
☐ diarrhea
☐ abdominal pain
☐ mucus in bowels
☐ gas

HEAD
☐ headache
☐ watery eyes
☐ puffy eyes
☐ itchy eyes
☐ popping in ears
☐ congested nose
☐ runny nose
☐ itchy nose
☐ sneezing

THROAT/CHEST
☐ coughing
☐ wheezing
☐ congested chest
☐ shortness of breath
☐ sore throat
☐ itchy throat

**FREQUENCY/TIME AND DURATION OF SYMPTOMS** (Check the appropriate response below)

☐ sporadic (at various times of the year but with no pattern)
☐ persistent (throughout the year)
☐ seasonal (indicate the prominent months below)
☐ Jan ☐ Feb ☐ Mar ☐ Apr ☐ May ☐ Jun
☐ July ☐ Aug ☐ Sep ☐ Oct ☐ Nov ☐ Dec

DURATION
☐ minutes
☐ hours
☐ days

TIME OF DAY
☐ morning
☐ afternoon
☐ evening
☐ after meals

**SURROUNDINGS** (Indicate where/when symptoms occur below)

OUTDOORS
☐ after mowing lawn
☐ in damp areas
☐ while driving
☐ while taking walks
☐ while exercising
☐ near farms/barns

INDOORS
☐ in basement/crawl space
☐ after dusting/vacuuming
☐ at school
☐ after exercising
☐ near burning leaves
☐ at work (if checked, indicate occupation) _____

☐ in bedroom
☐ in kitchen
☐ in attic

TYPE/LOCATION OF HOME
- ☐ single family
- ☐ apartment/condominium
- ☐ mobile home
- ☐ in city
- ☐ in suburbs
- ☐ in heavily wooded area
- ☐ in farming area

HEATING SYSTEM
- ☐ forced air
- ☐ electric
- ☐ oil
- ☐ coal
- ☐ radiant

COOLING SYSTEM
- ☐ air conditioner
- ☐ oscillating fan(s)
- ☐ ceiling fan(s)

**BEDROOM** (Indicate which items below are found in your bedroom)
- ☐ carpet
- ☐ vinyl or wood floors
- ☐ drapes
- ☐ vertical blinds
- ☐ venetian blinds
- ☐ dehumidifier
- ☐ cotton pillow
- ☐ feather pillow
- ☐ foam rubber pillow
- ☐ books
- ☐ stuffed animals
- ☐ fans (ceiling or oscillating)
- ☐ air conditioner (if checked see below)
  - ☐ central
  - ☐ individual unit
- ☐ cotton mattress
- ☐ feather mattress
- ☐ foam rubber mattress
- ☐ waterbed mattress

**PETS**
- ☐ own pet(s) If checked, indicate the pet(s) below
- ☐ visit home/farm that has pets. If checked, indicate the pet(s) below
  - ☐ cat
  - ☐ dog
  - ☐ horse
  - ☐ bird
  - ☐ hamster
  - ☐ rabbit
  - ☐ other (list) _____

**INSECT BITES**

Have you ever had a severe reaction to insect bites? ☐ Yes ☐ No

Have you been stung by an insect within the last six months? ☐ Yes ☐ No

If you checked yes to either question above, indicate the insect:
- ☐ wasp
- ☐ hornet
- ☐ yellow jacket
- ☐ honey bee
- ☐ tick
- ☐ flea
- ☐ mosquito
- ☐ spider
- ☐ ant
- ☐ other (list) _____

**MEDICATIONS** (Check any medications that you are presently taking)
- ☐ aspirin
- ☐ corticosteroids
- ☐ sedatives
- ☐ birth control
- ☐ vitamins
- ☐ nose drops/sprays
- ☐ hormones
- ☐ other (list) _____

Are you or do you think you are allergic to any drugs? ☐ Yes ☐ No

If yes, list: _____

**CONTACTANTS** (Indicate any substance below that may cause your symptoms or make them worse)
- ☐ laundry soap
- ☐ dish detergent
- ☐ hand soap
- ☐ shampoo
- ☐ cotton
- ☐ perfume/cologne
- ☐ cosmetics
- ☐ newspapers/magazine print
- ☐ wool

**DIETARY INFORMATION** (Indicate how often you eat the following foods)

| | Daily | Weekly | Rarely | Never | | Daily | Weekly | Rarely | Never |
|---|---|---|---|---|---|---|---|---|---|
| ☐ milk | ☐ | ☐ | ☐ | ☐ | ☐ beef | ☐ | ☐ | ☐ | ☐ |
| ☐ eggs | ☐ | ☐ | ☐ | ☐ | ☐ tuna | ☐ | ☐ | ☐ | ☐ |
| ☐ wheat(bread) | ☐ | ☐ | ☐ | ☐ | ☐ codfish | ☐ | ☐ | ☐ | ☐ |
| ☐ corn | ☐ | ☐ | ☐ | ☐ | ☐ rice | ☐ | ☐ | ☐ | ☐ |
| ☐ chocolate | ☐ | ☐ | ☐ | ☐ | ☐ cereal | ☐ | ☐ | ☐ | ☐ |
| ☐ peanuts | ☐ | ☐ | ☐ | ☐ | ☐ potato | ☐ | ☐ | ☐ | ☐ |
| ☐ orange | ☐ | ☐ | ☐ | ☐ | ☐ peas | ☐ | ☐ | ☐ | ☐ |
| ☐ soybean | ☐ | ☐ | ☐ | ☐ | ☐ beans | ☐ | ☐ | ☐ | ☐ |
| ☐ pork | ☐ | ☐ | ☐ | ☐ | | | | | |

☐ List foods that you think give you trouble: _____

**MISCELLANEOUS** (Please answer the following questions)

Do you smoke? ☐ Yes ☐ No

Does anyone else in your household smoke? ☐ Yes ☐ No

Are you exposed to unusual fumes at work or home?

If yes, list: _____

Are you presently under any unusual form of stress? ☐ Yes ☐ No

Have you ever been treated for allergies before? If yes, indicate type of treatment.

☐ antihistamines ☐ corticosteroids ☐ immunotherapy (allergy injections)

Effectiveness of treatment: ☐ poor ☐ fair ☐ good