NAPLES ALLERGY CENTER
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MEDICAL HISTORY AND ALLERGY SURVEY

Please complete this form to the best of your knowledge. The history you provide on your medical condition(s) and your symptoms will help your doctor help you.

NAME _____ **AGE**_____**DATE**_____
Please circle the allergy problem(s) that apply to you:

1. Hay fever/rhinitis	6. Hives/eczema/rash	11. Food allergy
2. Itchy eyes/conjunctivitis	7. Diffuse Itching	12. Insect sting/bite allergy
3. Asthma/bronchitis/cough	8. Swelling: Lip Eye Tongue Face	13. Drug allergy or intolerance
4. Sinus infections	9. Ear pressure or pain	14. Immune system problem
5. Itchy ears, mouth, throat	10. Headache	15. Anaphylaxis/shock

WHY ARE YOU HERE? (Describe your allergy symptoms)_____

_____

Pharmacy Name_____ **Where do you go for Lab/blood work**_____

1) What doctor has diagnosed your symptoms**?**

_____

2) What was the diagnosis**?**

_____

3) What is the treatment recommended

_____

4) How is the treatment working for you**?**

_____

5) Why are you here, did your doctor recommend you see an allergist

_____

6) What would you like to accomplish**?**

_____

III. SYMPTOMS please (circle) problems

Eyes:	Itch	Swell	Burn	Tear/watery	Discharge	Red
Ears:	Itch	Congested	Popping	Hearing Loss	Pressure	Pain
Nose:	Itch	Congested	Sneeze	Runny	Mouth Breath	Snore
	Pressure	Headache	Nose Bleeds	Can't Breath	Can't Smell	Irritation
	Drainage:	- clear/white	- yellow	- green	- thick	- watery
	Worse:	- morning	- day	- night	- outdoors	- indoors
Throat:	Itch	Sore	Post Nasal Drip	Throat Clearing	Swelling	Dry
Lungs:	Wheeze	Tightness	Short of Breath	Cough	Awaken you at night	
	Phlegm	Color:	- clear	- white	- yellow	- green
	Cough/wheeze worse with:		- laughter	- exercise	- at night	- talking
Skin:	Itch	Hives	Red	Swelling	Rash	Eczema

Where on your body? _____

IV. REVIEW OF ALLERGIC HISTORY

Age or onset of allergies. _____

Do you have symptoms: Daily Seasonal Both Varies Not Sure

Are your allergies **worse**, more severe, or more frequent? _____

Does exposure to anything make your symptoms worse? (Please list: cat, dog, dust, grass, smoke, perfume)

_____

Please list any **food** allergies and what occurs each time this food is eaten: _____

_____

_____

Have you had a life-threatening reaction to the **sting** of fire ants, wasp, yellow jacket, hornet, or honey bee?
_____

What happens when stung?_____

How soon after being stung does this reaction occur?_____

V. PREVIOUS ALLERGY EVALUATION AND TREATMENT

Name of previous allergist: _____ City/State: _____ Date: _____

Did you have a **skin test**? Yes No Or **blood** test (RAST) for allergies? Yes No When:_____

Please list your allergies: _____

Were you on allergy shots? Yes No

How long did you receive allergy shots? _____

How many allergy injections did you receive each time: _____

How frequently did you receive your injections: _____

VI. RASH, HIVES, ECZEMA – (Complete this section, only if you are being evaluated for a rash.)

When did your rash first start? _____

Have you ever had this rash, hives, or eczema in the past? Yes No When? _____

_____

Describe the circumstances surrounding your first episode of the rash. What do you think was the cause?

_____

How **often** does the rash occur now? _____

Is the rash getting worse, occurring more often, or lasting longer? _____

How long does each hive/lesion **persist**? _____

Where on your skin does the rash usually occur the most? _____

Do the hives consistently appear on your hands, feet, or buttocks? _____

Do your hands or feet itch? _____

What are the sizes of the individual lesions or hives? _____

Does the rash **itch**? Yes No Does lightly stroking your skin cause the rash or hives? Yes No

Does itching precede the rash, or does the rash develop first and then itch? **Itch→Rash** or **Rash→Itch**

Is there a pattern or cycle your rash follows? _____

What time of day does the rash or hives seem to be worse? _____

Is the rash or hives worse during a particular season or month(s)? _____

Is the rash worse: - indoors - outdoors - work - home - school

Is the rash worse or better: - on vacation - same regardless of location - since moving to Florida

What is the longest period of time you have been without the rash? _____

What **medications** have you used to treat the rash? (Antihistamines, steroids, creams, etc.)

_____ effective / not effective _____ effective / not effective

_____ effective / not effective _____ effective / not effective

_____ effective / not effective _____ effective / not effective

Do any of these medications help, but the rash get worse afterwards? _____

Do any of the following cause your rash to start or worsen?				Aspirin	Alcohol	Tobacco
Water	Cold	Heat	Hot bath/shower	Exercise	Emotion	
Sunlight	Sweating	Exertion	Excitement	Vibration	Stress	
Pressure		Tight clothes	Elastic-Latex	Caffeine	Rubbing	other
Are any of the following associated with your rash?				Excess sweating	Diarrhea	Fever
Headache		Faintness	Listlessness	Muscle Ache	Weight Loss	Cramps
Joint Pain		Joint Swelling	Joint Stiffness	Flush	Nausea	Vomit

Does your asthma or hay fever worsen when you develop the rash? _____

Do you know of any household or work exposures that may cause your rash? _____
_____

Have you ever had a problem with contact dermatitis (Poison Ivy, soap, jewelry, etc.)? Yes No

Do you have any contact with the following plants: Mango Brazilian Pepper Oleander Pecan

Does contact with metal, jewelry, or nickel cause a rash or eczema? _____

Does any detergent, soap, or fabric softener make your rash worse? _____

What brand of detergent do you use? _____ Soap? _____ Softener? _____

Any medication, drugs, antibiotics, or X-ray dyes cause you to develop a rash? (Please list on next page)

Do any meals or particular foods cause your rash to worsen? _____

Have you eliminated any foods from your diet, which reduced your rash? _____

Is your rash worse or during your menstrual period? _____

Have you been to a dermatologist, and if so, whom: _____

Did you have a skin biopsy?_____ What were the results? _____

VII. ENVIRONMENTAL HISTORY

Where do you work or go to school? _____

Do you suspect anything in your work or school environment to cause your symptoms to worsen? _____
_____

What type of home do you live in? House Villa Apartment Townhouse Condo Trailer

How old is home? _____years old Are you the original owner? Yes No

Where is your home, what neighborhood do you live in? _____

Are you near: Gulf Beach Lake River Swamp
Canal Park Golf Course Wooded area Undeveloped Preserve

Do you have any indoor **pets** (cat, dog, hamster, gerbil, guinea pig, ferret, bird)? _____

Do you have any outdoor pets (cat, dog, horses)? _____

How old is your **mattress**? _____ years old How old are your pillows? _____years old

Your **pillows** are: Feather/Down , Foam, Dacron, Polyester, or Fiber-fill? _____

Do you have **carpeting** in your bedroom? Yes No **Curtains** in your bedroom windows? Yes No

Do you have **shelves** in your bedroom? Yes No **Upholstered** furniture in your bedroom? Yes No

Do you have **throw pillows** on your bed? Yes No Or **stuffed animals** in your bedroom? Yes No

Do you practice any **environmental control** measures for allergens in your home? _____

Do you have central **air conditioning**? Yes No Does air conditioning **help** your symptoms? Yes No

Do you keep the windows: open closed open in the cooler months

Does your symptoms: - improve - worsen . . . when on/at: - vacation/trips - beach

Do you have symptoms after eating at home or in a restaurant? _____

Does a change in the **weather** influence your symptoms? _____

Do strong **odors**, **perfumes**, powders, cleaners, cigarette **smoke** make you worse? _____

Does strenuous activity or **exercise** affect your symptoms? _____

VIII. MEDICATION (Please ***circle current** use* and underline past use)

Antihistamines: Allegra Allegra-D Allerx Benadryl Chlorpheneramine

Claritin/Loratadine Claritin-D Clarinex Dallergy Hydroxyzine/Atarax

Tavist Zyrtec Zyrtec-D Xyzal other: _____

Symptoms: - improved - not improved - sedation - reaction_____

Decongestants: Entex Profen Sudafed Duratuss other

Symptoms: - improved - not improved - insomnia - reaction_____

Nasal Sprays: Afrin Astelin Astepro Atrovent Beconase Flonase

Fluticasone Ipratropium Nasarel Nasacort Nasochrom Nasonex

Neosinephrine Omnaris Patanse Rhinocort Vancenase Veramyst

Symptoms: - improved - not improved - irritation - reaction_____

How often did you dose this medication? _____

AsthmaSteroid Inhalers: Aerobid Alvesco Asmanex Azmacort Dulera

Flovent HFA 44, 110, or 220 Flovent Diskus 100, 250, 500 Pulmicort QVAR

Symbicort Advair Diskus 100/50, 250/50, 500/50 Advair HFA 45/21, 115/21, 230/21

Symptoms: - improved - not improved - irritation - reaction_____

How often did you dose this medication? _____

Bronchodilators: Albuterol Alupent Atrovent Combivent Foradil

Maxair Primatene Mist ProAir Proventil Serevent Spiriva Ventolin Xopenex

Cromolyn Intal Tilade

Symptoms: - improved - not improved - irritation - reaction_____

How often did you dose this medication? _____

Theophylline: Slo-Bid Theo-Dur Theo-24 Unidur Uni-phyl

Symptoms: - improved - not improved - irritation - reaction_____

How often did you dose this medication? _____

Leukotriene Modifiers: Accolate Singulair Zyflo Zyflo CR

Symptoms: - improved - not improved - irritation - reaction_____

How often did you dose this medication? _____

OralBronchodilators: Albuterol tabs Proventil tabs Volmax Vospire ER

Symptoms: - improved - not improved - irritation - reaction_____

How often did you dose this medication? _____

Nebulized Medication: Albuterol nebs Brovana Budesonide/Pulmicort Respules DuoNeb

Ipratropium/Atrovent Perforomist Xopenex

Symptoms: - improved - not improved - irritation - reaction_____

How often did you dose this medication? _____

OralSteroids: Medrol Prednisone Prednisolone Sterapred

Symptoms: - improved - not improved - irritation - reaction_____

How often did you dose this medication? _____

Eye Allergy Drops: Alamast Alocril Alomide Bepreve Crolom

Elastat Naphcon-A Opcon-A Optivar Pataday Patanol Refresh Restasis

Visine-A Zaditor other

Symptoms: - improved - not improved - irritation - reaction_____

How often did you dose this medication? _____

Antibiotic: (to treat sinusitis or bronchitis) _____How long _____

Antibiotic: _____How long _____Antibiotic: _____How long _____

Symptoms: - improved - not improved - irritation - reaction_____

Medications: (Please list all other medications you are taking including prescribed, over-the-counter, aspirin, vitamins, laxatives, sleeping medication, cold medication, contraceptives, and herbal medication)

_____

_____

_____

_____

IX. DRUG ALLERGIES & INTOLERANCES (Please list drug, type of reaction, and date of reaction)

_____

_____

_____

_____

X. PAST MEDICAL HISTORY

Do you have a history of any of the following: Arthritis Diabetes Heart Disease Stroke

Cholesterol Hypertension Thyroid Reflux Hiatal Hernia Ulcers

Depression Anxiety Insomnia Osteoporosis Hepatitis Seizures

Cataracts Glaucoma Cancer Prostate Irritable Bowel Lupus

Please list any other medical problems you have: _____

_____

Please list all surgery you have had: _____

_____

Have you ever been hospitalized for asthma or other medical problems: _____

_____

Have you ever had repeated infections, sinusitis, pneumonia, or sore throats? _____

_____

Have you had sinus surgery, drainage procedures, or polyps removed? _____

_____

Does aspirin or Motrin cause your nose to fill up, shortness of breath, or other respiratory reaction? _____

_____

Do you feel a lack of energy, anxiety, or depression? _____

Have you ever had: Chest X-ray Sinus X-ray CT scan Lung function testing

EKG Blood tests Skin tests Patch tests Skin biopsy

Are your vaccinations up to date? Yes NoDo you get the Flu vaccine each year? Yes No

Have you received the Pneumonia Vaccine? Yes No If you have, when: _____

The Tetanus vaccine (in the past 10)? Yes No If you have, when: _____

XI. FAMILY HISTORY

Does anyone in your family have asthma, allergies, hay fever, food allergy, drug allergy, insect allergy, eczema or rash, recurring or frequent infections, or arthritis? _____

_____

_____

Are there any other diseases that run in your family: Diabetes, emphysema, thyroid disease, heart disease?

_____

_____

XII. PERSONAL AND SOCIAL HISTORY

Do you **smoke**? Yes No Did you ever smoke? Yes No If you quit smoking, when did you quit? _____

How many **packs** per day and how many **years** did you smoke?_____

How much alcohol do you drink? _____

Do you use any recreational drugs? (*This is confidential*) _____

What is/was your occupation? _____

If you are student, what school do you attend and your grade level: _____

Are you exposed to toxic chemicals, noxious substances, or cigarette smoke? _____

How long have you lived in Bonita, Estero, Marco, Naples, or Ft Myers? _____ in Florida? _____

Where else have you lived? _____

Are you happy with your life? Yes No If not, why? _____

How many people live in your home? _____ Do any of them smoke? _____

Circle With whom do you live: Mother Father Brother(s)

Sisters(s) Children

Husband Wife Grandparent Cousin(s) Uncle Aunt

In-laws Roommate Boyfriend Girlfriend Significant Other

XIII. REVIEW OF SYSTEMS (Please circle any of the following that may apply to you)

General: Weight loss Chills Fevers Dry Mouth Loss of appetite

Eyes and ears: Dry eyes Vision changes Hearing loss Ringing in ears

Skin: Rashes Acne Bruising Recurrent infections

GI: Nausea Vomiting Diarrhea Heartburn Trouble swallowing

Constipation Bloating Belching Excessive gas Change in bowel habits

Cardio: Chest pain Calf pain Ankle swelling Angina Palpitations

Kidney: Trouble starting urination Burning with urination Frequent Urination

Frequent night time urination Bed wetting Lose of urine with sneezing or coughing

Blood: Anemia Bleed easily Bruise Swollen Lymph Nodes

Musculoskeletal: Joint pain Joint stiffness Joint swelling Morning stiffness

Back pain Neck pain Muscle pain Muscle weakness

Endocrine: Cold intolerance Heat intolerance Increased thirst Flush

Gyn: Excess bleeding Vaginal discharge Change in menstrual cycle

Neurological: Weak Clumsiness Tingling Burning Numb

Psych: Anxious Excessive worry Crying spells Poor sleep Excess sleep Behavior

Other: Groin rash Nail changes Lumps under skin

Is there any Doctor you would like us to release information about your evaluation and treatment

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Please bring in copies of any previous testing, notes, prior treatments, labs, skin biopsy reports, etc.

_____ _____

Patient Signature ***Date***

Email Address _____

Cell Phone Number _____