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BOARD CERTIFICATION
Otolaryngology
Facial Plastic Surgery
Sleep Medicine

ALLERGY HISTORY FORM

NAME: ________________________________ DATE: _________ DOB: ______________

1. Have you ever been allergy tested before? __________ When? _________________________
    - Were you ever on allergy shots? _________
    - For how long? _______________________
    - What type of testing-scratch, prick, or intradermal skin testing? _______________
2. Have you ever had sinus surgery?__________ When? _________________________________
3. Do you have pets or exposure to pets on a regular basis?_______________________________
    - What type of pet(s)?____
4. How old is your dwelling? ______
    - Have you seen mold in the dwelling?_______
    - Has your dwelling ever been tested for mold?________
    - What type of heating system do you have? (Gas, electric, oil etc.) ___________
    - Do you have air conditioning? _______________________________________
    - Do you have an air-purifier or humidifier? ____________________________________
5. Do you have carpets, upholstered furniture, and/or heavy drapes in your dwelling?
   ____
6. What do you do for a living? ____
    - What is your work environment like? (i.e. ventilation system, dust, mold, etc)
      ____
7. What types of symptoms do you experience (i.e. nasal congestion, itchy or clogged ears, postnasal drip, itchy, watery, and/or swollen eyes; frequent sneezing, chronic coughing, headaches, hoarseness)?

8. Do you have wheezing or diagnosed asthma? ____________ What medications do you use?
____

9. Do you get hives or have chronic skin rashes/eczema?
____

10. Do you have any food allergies that you know of? ________________________________

11. Have you ever had hives or anaphylaxis (difficulty breathing, throat or tongue swelling) after eating a certain food?____
    - If so, what food?
      ____

12. Do you often have diarrhea, gas, heartburn, nausea, vomiting, and/or chronic abdominal pain?
____
    - Do you notice increase in these symptoms after eating a certain food? ________________
    - What foods? ____

13. What medications have you tried for your allergy symptoms? _________________________
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