Brett Clarke, M.D., M.S.

PINON HILLS
Ear, Nose, Throat & Allergy

Stephen Smith, PA-C

ALLERGY CASE HISTORY

PATIENT'S NAME_____AGE__SEX__DATE_____

PARENT (for minor under 18) _____

OCCUPATION_____

CHIEF COMPLAINTS

_____

_____

CHECK ANY CONDITIONS THAT APPLY TO YOUR SYMPTOMS

- ☐ Worse on windy days
- ☐ Worse outdoors between 6-10 am
- ☐ Worse outdoors from 4-9 pm
- ☐ Worse indoors
- ☐ Worse after going to bed
- ☐ Worse during change of season
- ☐ Better on rainy days
- ☐ Worse when sweeping or dusting
- ☐ Worse when mowing or sitting in grass
- ☐ Worse in basements
- ☐ Worse raking wet leaves
- ☐ Worse when furnace is turned on for winter
- ☐ Worse when air conditioning is turned on for summer
- ☐ Worse around animals (which ones?)

During what months do you usually have symptoms?

- ☐ All year
- ☐ January
- ☐ February
- ☐ March
- ☐ April
- ☐ May
- ☐ June
- ☐ July
- ☐ August
- ☐ September
- ☐ October
- ☐ November
- ☐ December

During which season are symptoms most severe?

- ☐ Spring
- ☐ Summer
- ☐ Fall
- ☐ Winter

Are your symptoms: ☐ constant ☐ intermittent

MEDICATIONS

What prescription and non-prescription medications do you take?

_____

_____

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What medications relieve your allergy symptoms?_____

Do you take a Beta Blocker? ☐ Yes ☐ No If yes, name of medication_____

MEDICAL HISTORY

Please select all that apply:

☐ High Blood Pressure	☐ Nasal Surgery	☐ Immune Disorder	☐ Asthma
☐ Thyroid Dysfunction	☐ Pneumonia	☐ Hay Fever	☐ Emphysema
☐ Seizures	☐ Heart Disease	☐ Nasal Polyps	☐ Colitis
☐ Bronchitis	☐ Arthritis	☐ Milk Allergy	☐ Ulcers
☐ Skin Disease	☐ Chronic Fatigue	☐ Frequent Headaches	☐ Deviated Septum
☐ Sinus Infections	☐ Cancer	☐ Migraine Headache	☐ Other:_____

Previous allergy testing? ☐ Yes ☐ No Year:_____ Where: _____

Type of Testing: ☐ Scratch ☐ Intradermal ☐ RAST

Did you take allergy shots? ☐ Yes ☐ No

How long?_____ Did your symptoms improve? ☐ Yes ☐ No

Did you give your own allergy shots? ☐ Yes ☐ No

Do you have a family history of allergies? ☐ Yes ☐ No

ALLERGY SYMPTOMS

Nose:	Ears:	Throat:	Mouth:	Eyes:
☐ Stuffy	☐ Stopped up	☐ Post-nasal drip	☐ Roof itching	☐ Watery
☐ Runny	☐ Itching	☐ Mouth breather	☐ Tongue coated	☐ Itching
☐ Itching	☐ Sore	☐ Wake up with dry throat	☐ Ulcerated	☐ Swelling
☐ Nosebleeds	☐ Hearing loss	☐ Mucus in AM	☐ Lips swell	☐ Burning
☐ Loss of smell	☐ Ringing/roar	☐ Itching	☐ Swallowing difficulty	☐ Red
	☐ Dizziness	☐ Hoarse voice	☐ Loss of taste	☐ Dark Circles

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Cough:
- ☐ Year round
- ☐ Seasonal
- ☐ Daytime
- ☐ Nighttime
- ☐ Worse after a cold
- ☐ Dry
- ☐ Loose

Sneezing:
- ☐ Year round
- ☐ Seasonal
- ☐ In early A.M.
- ☐ At meal time
- ☐ 30 min. after eating
- ☐ Smoky places
- ☐ Dust

Respiratory:
- ☐ Wheezing
- ☐ Chest tightness
- ☐ Short of breath
- ☐ Allergy-induced asthma
- ☐ Exercise induced asthma

Mucus:
- ☐ Thin
- ☐ Thick
- ☐ Clear
- ☐ Colored
- ☐ Source:
  - ☐ Nose
  - ☐ Throat
  - ☐ Lungs

Skin:
- ☐ Eczema
- ☐ Hives
- ☐ Rash
- ☐ Itching
- ☐ Where?_____ _____ _____

CHECK ANY OF THE FOLLOWING THAT AGGRAVATE YOUR SYMPTOMS:

- ☐ Paint fumes
- ☐ Dust
- ☐ Perfumes/colognes
- ☐ Smoke
- ☐ Air pollution
- ☐ Plants/flowers
- ☐ Wool
- ☐ Insect Spray
- ☐ Newspapers
- ☐ Cosmetics
- ☐ Cleaning products
- ☐ Barns

Any known or suspected food allergies? _____

PERSONAL PETS

- ☐ Dog Indoors? • Yes • No In your bedroom? • Yes • No
- ☐ Cat Indoors? • Yes • No In your bedroom? • Yes • No
- ☐ Birds
- ☐ Gerbil/Hamster
- ☐ Horse

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FOOD ALLERGY SCREENING QUESTIONNAIRE

Name: _____ Date: _____

Yes No 1. Are there any foods or beverages you (a) crave or (b) eat frequently?
(a) _____ (b) _____
_____ _____
_____ _____

Yes No 2. Are there foods or beverages that disagree with you or make you sick?
List:_____

Yes No 3. Do you wake between 1 AM and 5 AM with any of the following symptoms: headache, dizziness, stomach cramps, bloating, dry cough? (Please circle which)

Yes No 4. Do you have a family history of hay fever, asthma, hives, chronic skin conditions, migraine headaches, or colitis? (Please circle which)

Yes No 5. During infancy or childhood did you have eczema, hay fever, asthma, or food feeding problems? (Please circle which)

Yes No 6. Do you ever have skin rashes, hives, or itching of the roof of your mouth? (Please circle which)

Yes No 7. Do you frequently notice swelling of your ankles, feet, hands or face upon waking in the morning?

Yes No 8. Do you have *marked* fatigue two to three hours after meals?

Yes No 9. Do you eat snacks between meals frequently? List examples:
_____

Yes No 10. Do you chill easily with sudden temperature changes?

Yes No 11. Do you have frequent headaches or migraines? (Please circle which)
Location:_____

Yes No 12. Do you have belching, bloating, gas or cramps after meals?

Yes No 13. Do you have frequent diarrhea or alternate between diarrhea and constipation?

Yes No 14. Do you have recurring fungal infections (vaginitis, athlete's foot, jock itch)?

Yes No 15. Have you noticed numbness of the face, arms or legs at periodic intervals for no apparent reason?

Yes No 16. Do you have intermittent ringing in the ears or dizziness? (Please circle which)

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