

Allergy History Survey

Name _____ Date _____

Occupation _____ Age _____

COMPLAINTS:

Please circle the appropriate number 1-5 according to severity: 1 = mild, 5 = very severe, 0 = no problem

Nasal Discharge	0 1 2 3 4 5	Chronic Fatigue	0 1 2 3 4 5
Nasal Obstruction	0 1 2 3 4 5	Food Intolerance	0 1 2 3 4 5
Watery or itchy eyes	0 1 2 3 4 5	Frequent sinus or ear infection	0 1 2 3 4 5
Sneezing	0 1 2 3 4 5	Frequent colds or sore throats	0 1 2 3 4 5
Wheezing	0 1 2 3 4 5	Learning disability	0 1 2 3 4 5
Cough	0 1 2 3 4 5	Poor memory or concentration	0 1 2 3 4 5
Itching	0 1 2 3 4 5	Hyperactivity	0 1 2 3 4 5
Eczema	0 1 2 3 4 5	Abdominal gas or cramping	0 1 2 3 4 5
Hives	0 1 2 3 4 5	Arthritis or muscle aching	0 1 2 3 4 5
Headache	0 1 2 3 4 5	Asthma	0 1 2 3 4 5

Other symptoms _____

Which (if any) foods cause you any problems? _____

In what year did your allergies start? _____

How many months of the year do you have allergies? _____

Have you been allergy tested before? _____ If yes, did you receive desensitization shots? _____

What prescription medications have you tried for allergies? How long did you use them?

1. _____ For how long? _____

2. _____ For how long? _____

3. _____ For how long? _____

4. _____ For how long? _____

Does any medication give you relief of symptoms? _____

List any animals you have in or around the home _____

Are you exposed to fumes or dust at work? _____

Do you smoke? _____ How much? _____ Smokey work environment? _____

Who else in your family has allergies? _____

How did you hear about ENT Specialists of Arizona? (Be specific. If a newspaper, please give name)

Patient Signature Date

Physician Signature