Villa Rica Ear Nose and Throat
Allergy History Form

Date: ____________________

Name: ____________________________________ Date of Birth: ___________

1 Have you ever been allergy tested before? Yes No
If yes, when? ___________________
2 Were you ever on allergy shots? Yes No
If yes, for how long? __________________
3 Do you have pets or are exposed to pets on a regular basis? Yes No
What kind of pets? __________________
4 How old is your home? ________________
What type of heating and air system does your home have?
____
Do you have an air purifier or humidifier? Yes No
Have you ever seen mold in your home? Yes No
Has your home ever been tested for mold? Yes No
If yes, when? ___________________
Do you have carpet, upholstered furniture or drapes in your home? Yes No
5 What is your occupation? ______________________________
What is your work environment like? (Dust, mold, pollen)
____
6 Do you get hives or any other rashes on your skin? Yes No
If yes, when do they occur? _____________________
7 During what months/seasons do you experience the majority of your symptoms?
____
8 Do you have any food allergies that your aware of? Yes No
If yes, what?________________________
9 Have you ever had ANY reactions to any type of food? Yes No
If yes, what?________________________
10 Do you often have diarrhea, severe gas, heartburn, nausea, vomitting, and/or chronic abdominal pain after eating certain foods? Yes No
If yes, what food? _______________________
11 Do you have persistent food cravings? Yes No
If yes, what food? _______________________

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12 Please list all major medical problems.

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13 Please list all medications you take on a regular basis including over the counter.

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14 What types of symptoms do you experience? (nasal congestion, itchy watery eyes, post nasal drip, swelling of the face or eyes, sneezing, coughing, headaches)

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15 What medications have you tried for your allergy symptoms?

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16 What medications seem to relieve or improve your allergy symptoms?

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