ALLERGY DATA SHEET

Alan McCrory, M.D.

1. Name: ____ Sex: ______ Age: ____________ Date of visit: ______________________
   Referred by / Primary Physician: ____ Weight: ______________ Height: ______________

CHIEF COMPLAINT(S): *Circle the type of problem(s) for which you seek an evaluation*

Hay fever, Asthma, Eczema, Chronic cough, Chronic hives, Food allergy, Drug allergy, Reaction to insect sting, Other

HAY FEVER (nose / sinus / eye) symptoms

2. *How long have you had hay fever symptoms? ________ yrs/mths*

(CHECK THAT APPLY)	none	mild	mod	severe
a) Runny nose				
b) Sneezing				
c) Nasal congestion				
d) Post nasal drip				
e) Red, itchy & watery eyes				
f) Itchiness of nose				
of throat				
of palate				
of ears				
g) Nose bleed				
h) Sinus headaches				
i) Impaired taste / smell				
j) Cough				

ASTHMA (chest) symptoms

3. *How long have you had asthma symptoms? __________ yrs/mths*

(CHECK THAT APPLY)	none	mild	mod	severe
a) Cough +/- Phlegm				
b) Wheezing				
c) Shortness of breath				
d) Chest tightness				
e) Symptoms with exercise				
f) Lump in the throat				
g) Choking, Loss of speech				

SKIN (Eczema / Hives)

4. *How long have you had skin symptoms?*

(CHECK THAT APPLY)	none	mild	mod	severe
a) Hives (Urticaria)				
b) Swellings (Angiodema)				
c) Eczema / Dry skin				

Answer question #5 if you have asthma symptoms. If not, skip to question #6

5. How often do you have asthma symptoms? Always Daily >2x per week <2x per week sporadic Other ________________
   Do asthma symptoms wake you up at night? YES / NO if yes, how many times a month / week ________________
   Number of Emergency Room / Urgent care visits for asthma in the past 12 months ______________
   Ever hospitalized for asthma? YES / NO Number of hospitalizations? __________ Last hospitalization ____________________
   Number of times on oral steroid courses (e.g.; Prednisone, Medrol dose pack, Steroid shots) in the past 12 months ________________
   How many days of work or school have you missed due to asthma in the past 12 months ____________________
   Do you monitor peak flow at home? YES / NO If so, what is your ideal peak flow? Morning ________ Evening __________
   Do you have stomach reflux symptoms (sour belching, heartburn, pain or difficulty swallowing) YES / NO

6. Do your symptoms vary with the seasons? YES / NO

If YES, place an "X" in the boxes when symptoms are worse

Symptoms	JAN	FEB	MAR	APRIL	MAY	JUNE	JULY	AUG	SEPT	OCT	NOV	DEC
Hay fever												
Asthma												
Eczema												
Hives												

7. Are you up to date on routine childhood vaccinations (immunizations)? YES / NO
   Influenza vaccine received: YES / NO when? ________ (Flu)
   Pneumococcal vaccine received: YES / NO when? __________ (Pneumonia)

***List over-the-counter and Prescription drugs used:** (include dose and frequency of use)*

CURRENT

____
____
____
____

PAST

____
____
____
____

Please continue on the next page

8. ***Check those triggers that cause or worsen your symptoms***

Hay fever	Asthma	Eczema / Hives	Triggers (circle or check all applicable)
			House Dust (Vacuuming, Dusting, Making bed, Shaking bed, Cleaning, Sweeping)
			Animals (cats, dogs, hamster, birds, guinea pig, other)
			Respiratory infections (Colds, sinus infections, Flu, Bronchitis)
			Exercise
			Night time
			Strong odors (newsprint, fumes), Perfumes, Air refreshers, Cleaners, Hair spray, etc.
			Emotional upset (Stress, Worry), Laughing
			Smoke (Tobacco, Auto exhaust, other)
			Cold air (air conditioning or outside air)
			Weather changes: Rain Cold Fronts Thunderstorm Wind
			Smog (Air pollution)
			Drugs (aspirin / ibuprofen, blood pressure medicine, glaucoma drops)
			Grass mowing, Raking leaves
			Foods / Food additives eg: Sulfites (in dried fruits, wine, beer etc.) / other
			Menstrual cycle, Pregnancy

9. ***Other allergies:*** **Food allergy?** YES / NO **Insect Sting reactions** (Bee, YJ, Wasp, Hornets, Fire ants)? YES / NO
Drug allergy? YES / NO **Latex rubber allergy?** YES / NO

Have you undergone allergy tests? YES / NO By whom? ______
Please list the results of your allergy testing? ______
Have you received allergy shots in the past? YES / NO when and how long? ______
Did the allergy shots help your symptoms? YES / NO ______

10. ***Home/Environmental survey*** ***(Fill in the blanks and circle those that apply)***
Years at present address: ______ ***Age of dwelling:*** _____ ***Dwelling Type:*** House Apartment Trailer Other ______
Trees around the house: Cedar Oak Maple Elm Pecan Pine Other ______ ***Lawn grass:*** Bermuda Fescue Other ______
Visible allergens inside the house: Mold-Mildew Roaches Rodents ***Indoor plants:*** Yes / No
Type of heating: Forced air Gas Radiators Electric Wood burning Space heaters Other ______
Types of cooling: Central Window unit fans none ***Humidifier use:*** *(Central / Portable)* *YES / NO*
Any indoor animals? (Dog, cat, hamster, bird, guinea pig, other ________) ***Outdoor animals?*** (cat, dog, horse, cattle, other ________)
Type of bed: Mattress / Box spring Waterbed Foam other ***Comforter:*** Feather / Non-feather
Type of pillow: Foam Feather Down Kapok Synthetic ***Water leakage or damage in your home:*** Yes / No
Carpets: YES / NO ***Basement present?*** YES / NO *If yes, is it damp?* Yes / No
Latex exposure in the home? Check all that apply (__ Playtex gloves ___ Balloons ___ Condoms or diaphragm)

11. ***Review of medical problems (Circle if present)*** Eczema Poison ivy/oak dermatitis Chr snoring Sleep apnea
Nasal polyps Heart burn/Reflux Stomach ulcers Diabetes Thyroid disorder Weight loss Chronic fever Glaucoma
Hypertension Elevated cholesterol Angina Heart failure Kidney stone Chr bronchitis/Emphysema Bronchiectasis
Chr abdominal pain Chr diarrhea Colitis Arthritis Migraine Anxiety/Depression Anemia Osteoporosis

12. ***Past history of diseases and surgeries:*** ***(Circle if present)*** **List surgeries:** ______
Asthma Eczema / Atopic dermatitis Chronic hives Thyroid disorder
Recurrent Pneumonia Recurrent Sinus infections Recurrent ear infections Ear tubes TB
Sinus surgery Tonsils surgery Adenoids surgery Nasal polyps Migraines

13. ***Family History*** Do any of your family members (parents, siblings, children) have the following conditions?
Hay fever Asthma Eczema Drug allergy Food allergy Chronic hives Colitis
Sinus problems Nasal polyps Cystic Fibrosis Emphysema Arthritis Migraine Glaucoma
Anxiety/depression Immune deficiency Hypertension Diabetes Thyroid disorder

14. ***Social History***
Marital Status: ______ ***Current Occupation:*** ______ ***Exposure to chemicals at work:*** YES / NO ______
Hobbies: ______ ***Smoking:*** YES / NO ***Year started smoking?*** ______ ***Number of Cigg / day*** ______
Quit smoking? Year ______ ***Does anyone smoke inside your home?*** YES / NO

History reviewed with the patient in detail: *YES / NO*