



Presbyterian Hospital of Allen
 1105 North Central Expressway, Suite 210
 Allen, Texas 75013

Office (972) 747-4646
www.entallen.com

ALLERGY HISTORY FORM

Date _____

Patient _____ Sex M F Date of Birth _____

Please describe your symptoms _____

Onset of symptoms _____

Do you ever experience any of the following (check all that apply)

Itchy eyes	<input type="checkbox"/>	Itchy nose	<input type="checkbox"/>	Itchy throat	<input type="checkbox"/>
Watery eyes	<input type="checkbox"/>	Runny nose	<input type="checkbox"/>	Daytime cough	<input type="checkbox"/>
Puffy eyes	<input type="checkbox"/>	Nasal congestion	<input type="checkbox"/>	Nighttime cough	<input type="checkbox"/>
Red eyes	<input type="checkbox"/>	Postnasal drip	<input type="checkbox"/>	Sore throat	<input type="checkbox"/>
Headache	<input type="checkbox"/>	Sneezing	<input type="checkbox"/>	Wheeze	<input type="checkbox"/>
Sinus pressure	<input type="checkbox"/>	Shortness of breath	<input type="checkbox"/>	Chest tightness	<input type="checkbox"/>
Popping in ears	<input type="checkbox"/>	Itchy ears	<input type="checkbox"/>	Chest congestion	<input type="checkbox"/>
Rash or hives	<input type="checkbox"/>	Eczema	<input type="checkbox"/>	Fatigue	<input type="checkbox"/>

List symptoms in order of severity:

- 1) _____
- 2) _____
- 3) _____
- 4) _____
- 5) _____

Are allergies worse indoors? Yes ___ No ___ Outdoors? Yes ___ No ___

Are your allergies worse: (check all that apply)

- | | |
|--|--|
| <input type="checkbox"/> Cleaning the house | <input type="checkbox"/> Damp weather |
| <input type="checkbox"/> The heat is turned on in the fall | <input type="checkbox"/> Around cut grass |
| <input type="checkbox"/> Outside in general | <input type="checkbox"/> Raking leaves in fall |
| <input type="checkbox"/> In the bedroom | <input type="checkbox"/> In an old home |
| <input type="checkbox"/> At work | <input type="checkbox"/> At school |

Season/Seasons allergy symptoms are worse _____

Do you have allergy symptoms year round? Yes _____ No _____

List any pets at your home: indoor: _____
outdoor: _____

What other pets are you exposed to? _____

What symptoms do you experience symptoms when around pets? _____

Do you smoke? Yes _____ No _____

Does it bother you to be around:
_____ smoke _____ perfume/fragrances/colognes _____ aerosol sprays

Do you use feather or down pillows or comforters? Yes _____ No _____

Do your symptoms increase with emotional or stressful events? Yes _____ No _____

Are symptoms aggravated when drinking wine or beer? Yes _____ No _____

Home environment: Flooring: carpet _____ tile _____ hardwood _____

Heating/cooling: electric _____ gas _____ ceiling fans Yes _____ No _____

How many houseplants? _____ Rooms houseplants are in: _____

How old is your home? _____ Any water or mold damage? Yes _____ No _____

Please, contribute any information that may be helpful in identifying your allergies or the cause of your symptoms:

Goals you wish to achieve with allergy shots (immunotherapy):

Family history of allergy:

	Yes	No
Mother	<input type="checkbox"/>	<input type="checkbox"/>
Father	<input type="checkbox"/>	<input type="checkbox"/>
Brother	<input type="checkbox"/>	<input type="checkbox"/>
Sister	<input type="checkbox"/>	<input type="checkbox"/>
Grandparents	<input type="checkbox"/>	<input type="checkbox"/>

Asthma:

	Yes	No
	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>