# Allergy History

1. List allergy symptoms: _____
_____
2. When did symptoms develop? _____
3. Are symptoms seasonal? If so, which seasons? _____
4. Do you have asthma? If so, what medications do you use to control your symptoms? _____
_____
5. Have you ever gone to the ER for allergies or asthma? _____
6. Have you had allergy testing in the past? If so, how long ago? _____
7. Do you own any pets? If so, what kind? _____
8. Is it OK to test both arms for intradermal injections? _____
9. Is there any possibility that you could be pregnant? _____
10. Please list any known allergies to:
    Medications: _____
    Food: _____
    Animals: _____

**Please check the situations that apply to you:**

**Pollen Allergy**

___ Aggravated outdoors
___ Aggravated with wind
___ Itching of the eyes
___ Aggravated on clear days
___ Improved in AC
___ Aggravated outdoors (7 AM to 11 AM)

**Dust Allergy**

___ Aggravated indoors
___ Increased within 30 minutes after going to bed
___ Increased each year with the return of cold weather
___ Nasal symptoms with little or no itching of eyes
___ Aggravated with AC
___ Increased when dusting/sweeping

**Mold Allergy**

___ Aggravated outdoors (4 PM to 8 PM)
___ Increased by cool evening air
___ Aggravated when mowing or playing on grass
___ Aggravated from mid August to December

**Please rate your symptoms on a daily basis (#1 is low degree, #5 is high degree):**

| | **CIRCLE THE NUMBER** | | | | |
|---|---|---|---|---|---|
| EYES (itchy, watery, or swelling): | 1 | 2 | 3 | 4 | 5 |
| EARS (itchy, draining, or congested): | 1 | 2 | 3 | 4 | 5 |
| NOSE (runny or congested): | 1 | 2 | 3 | 4 | 5 |
| HEADACHES (allergy related): | 1 | 2 | 3 | 4 | 5 |
| POST NASAL DRIP: | 1 | 2 | 3 | 4 | 5 |
| COUGH (allergy related): | 1 | 2 | 3 | 4 | 5 |
| SNEEZING: | 1 | 2 | 3 | 4 | 5 |