THE CENTERS FOR ADVANCED
ENT CARE
CHESAPEAKE EAR, NOSE, AND THROAT

Date:

ALLERGY HISTORY FORM

Patient Name: _____ Date of Birth: _____

Provider requesting allergy testing: **MDW** **MAM** **SDL** **DVS** **TNN** **PD** **MSS** **ARO**

What is the Major Reason(s) for this Allergy Testing?

_____

Complete the following section if there is a history of
NASAL AND EYE SYMPTOMS

Circle the following if they apply to you: NONE

Nasal Stuffiness Sneezing Post Nasal Drip Itchy Nose Itchy Eyes

Headache Ear Problems Other: _____

Nasal Discharge: NONE Clear White Yellow Green

When are you symptomatic? Winter Spring Summer Fall Year-Round

When are symptoms the worst? Winter Spring Summer Fall Year-Round

How long have you had these symptoms? _____

Medications you have taken for allergy symptoms: NONE

_____

_____

_____

Suspected or known causes of these symptoms: (circle all that apply)

Colds Dust Mold Cigarette Smoke Odors/Fumes

Trees Weeds Grass Mowing Lawn Foods

Dogs Cats Latex Weather Changes Barometric Pressure Changes

Other: _____

Do you have any pets at home? No If Yes, **what kind?** _____

Number of Sinus Infections treated in the past year: _____ NONE

Last Antibiotic: _____ NONE

Have you had a Sinus X-ray? No Yes - Date: _____

Have you had a Sinus Cat Scan? No Yes - Date: _____

History of Nasal Polyps? No Yes

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Date:

Complete the following section if there is a history of:
SKIN PROBLEMS

NONE Eczema Hives Rash Other: _____

Approximate date symptoms first noted: _____

Known or suspected causes of the rash: _____

Complete the following section if there is a history of
ASTHMA, WHEEZING, BRONCHITIS OR COUGH

Date Symptoms First Noted: _____

Description of symptoms: (circle all that apply)

Wheezing Cough Shortness of Breath

Chest Tightness Tightness in Throat Other: _____

Worse at night Worse during the day Problem during the day and night

Frequency of symptoms: Less than twice a week Everyday

3 or more days a week More than 2 nights a week

Emergency Room Visits: None 1-2 3-5 >5

Hospitalizations for above: None 1-2 3-5 >5

Asthma Medications you have taken: NONE

_____

_____

Suspected or known causes of these symptoms: (circle all that apply)

Colds Cats Dogs Animals Odors/Fumes Cigarette Smoke

Trees Weeds Mold Grass Mowing Lawn

Dust Latex Emotions Food Other: _____

Exercise Cold Air Wind Rain Outdoor Sports Weather Changes

Have you had any REACTIONS TO BEE/INSECT STINGS? NONE

Local reaction at sting site Rash Breathing Problems Other: _____

Have you had any PREVIOUS ALLERGY TESTING? No Yes (please continue below)

Date: _____ **Positive to:** _____

Previous Allergy Injections? No Yes - **Last Injection:** _____

Medicine Allergies: NONE Yes, _____

Is there a family history of allergies, asthma, nasal polyps, or chronic sinus disease? Yes No

Are you on any Beta Blockers? No Yes, _____