

**Virginia Ear, Nose & Throat Associates**  
**ALLERGY HISTORY**

Date: \_\_\_\_\_ Physician: \_\_\_\_\_ Chart # \_\_\_\_\_  
Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

**List the two major symptoms/reasons for which you are seeking testing:**

- 1. \_\_\_\_\_
- 2. \_\_\_\_\_

**Check all that apply:**

**Age of Symptom onset**

- Infant (0-5)  Adult (18 – 25)
- Child (age 6-12)  Adult (25 – 40)
- Adolescent (12-18)  Adult (over 40)

**Seasons when symptoms are Present/Worse**

- Spring  Worse
- Summer  Worse
- Fall  Worse
- Winter  Worse
- All year long

**Status of Symptoms**

- Stable
- Persistent/chronic
- Worsening
  - Days How many: \_\_\_\_\_
  - Weeks How many: \_\_\_\_\_
  - Months How many: \_\_\_\_\_
  - Years How many: \_\_\_\_\_
- Resolving/resolved

**Severity of Symptom**

- Mild - Slight interference with normal life
- Moderate - Prevents some normal activities
- Severe - Considerable interference with normal life

**Check all that apply**

**Nose Symptoms**

- Itching  Foul odor in the nose
- Runny nose-clear discharge  Loss of sense of smell
- Runny nose- cloudy or discolored discharge  Pain
- Sneezing  Stuffiness
- Dryness  Post nasal drainage
- Burning

**Check all that apply****Eye symptoms**

- |   |   |
|---|---|
| <input type="checkbox"/> Itching            | <input type="checkbox"/> Pain                           |
| <input type="checkbox"/> Excessive watering | <input type="checkbox"/> Dryness                        |
| <input type="checkbox"/> Redness            | <input type="checkbox"/> Dark circles under/around eyes |
| <input type="checkbox"/> Swelling           |   |

**Ear symptoms**

- Itching
- Blocking, fullness or popping, **circle those that apply**
- Hearing loss
- Pain
- Dizziness
- Ringing in ears

**Mouth and Throat Symptoms**

- |   |  |
|---|--|
| <input type="checkbox"/> Itching of the throat or mouth           | <input type="checkbox"/> Bad breath                      |
| <input type="checkbox"/> Frequent laryngitis/hoarseness           | <input type="checkbox"/> Dryness                         |
| <input type="checkbox"/> Frequent sore throats                    | <input type="checkbox"/> Swelling of the tongue or mouth |
| <input type="checkbox"/> Mouth sores                              | <input type="checkbox"/> Pain                            |
| <input type="checkbox"/> Burning sensation of the mouth or tongue | <input type="checkbox"/> Loss of sense of taste          |

**Chest Symptoms**

- Asthma or wheezing: \_\_\_ with exercise \_\_\_ without exercise
- Asthma or wheezing around animals
- Asthma or wheezing during pollen seasons
- Asthma or wheezing around tobacco smoke or chemicals
- Shortness of breath
- Coughing

**Severity of Pain Associated With Symptoms**

- |                                   |                                 |
|-----------------------------------|---------------------------------|
| <input type="checkbox"/> Mild     | <input type="checkbox"/> Severe |
| <input type="checkbox"/> Moderate | <input type="checkbox"/> None   |

**When are your symptoms Worse?**

- Outdoors
- With physical activity
- Indoors
- Nighttime
- Lying down
- Windy weather
- Damp or wet weather
- When weather changes
- During pollen seasons
- In certain rooms or buildings, if yes where \_\_\_\_\_
- When exposed to tobacco smoke
- With yard work, cut grass, leaves, hay or barns, **circle those that apply**
- When sweeping or dusting the house and/or dusty places
- In moldy or mildewy areas
- With air conditioning
- In fields or in the country
- Perfumes and fragrances
- Dogs
- Cats
- Birds/Feathers
- Don't know

**Check all that apply**

**When are your symptoms better?**

- After taking prescription nasal sprays
- After taking antihistamines
- After shower or bath
- With air conditioning
- Indoors
- During or after physical activity
- When it rains
- During snowy or icy weather
- During snowy or icy weather
- With allergy shots
- On vacation, if yes, where \_\_\_\_\_
- Saline sprays
- Sinus rinses
- Don't know

**Survey of the Home - Check all that apply**

- How old is your house or apartment \_\_\_\_\_ years?
- My house/apartment is damp
- My house/apartment is dry
- Things mildew easily in my house/apartment

**My house/ apartment is heated by**

- Gas
- Radiators
- Electric baseboard
- Open fireplaces/wood stove, **circle those that apply**
- Central heating system with duct

**My house/apartment is cooled by**

- An attic fan
- Window unit air conditioning
- Central air conditioning
- Window fans,  ceiling fans

**Which of the following describe your house/apartment**

- Plants and/or window boxes
- Use of insect sprays or moth repellants
- Piles of books or magazines
- Overstuffed furniture
- Feather pillows
- Rugs on the floor
- Carpeting
- Hardwood floors
- Heavy drapes at the windows
- Curtains at the windows
- Use of down comforters or pillows
- House/apartment often smells of fumes
- Wallpaper
- Basement
- Crawl space
- Animals : Cat  Dog  Other

**Check all that apply**

**Associated Features**

- Facial pain
- Headaches
- Polyps
- Deviated Septum
- Frequent sinus infections: # per year \_\_\_\_
- Frequent ear infections: # per year \_\_\_\_
- Frequent bronchitis episodes: # per year \_\_\_\_
- Ear tubes placed: Date \_\_\_\_\_

**Previous Treatment of Allergy Symptoms**

- Prescription of nasal sprays
- Antihistamines
- Allergy shots      Dates: \_\_\_\_\_
- Allergy drops      Dates: \_\_\_\_\_
- Other
- None

**Previous Diagnosis of Allergy with Allergy Testing and/or Treatment**

- Yes, I had skin testing      Date(s): \_\_\_\_\_
- Yes, I had blood testing      Date(s): \_\_\_\_\_
- No, I have not had allergy testing previously

**Diagnostic Tests:**

- Sinus CT Scan      Date: \_\_\_\_\_
- X-Rays      Date: \_\_\_\_\_
- MRI      Date: \_\_\_\_\_
- None

**List All Previous Ear, Nose and Throat Related Surgeries With Dates:**

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Do you smoke? \_\_\_\_\_ Are you a former smoker? \_\_\_\_\_

**LIST ALL CURRENT MEDICATIONS:** not just for allergy, including over the counter medications:

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