Peak ENT and Voice Center

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Allergy/Environmental History

Patient Name: _____ DOB: _____ Date: _____

Please fill out both pages completely.

I experience the following symptoms*:

Please circle all that apply:

Runny Nose Nasal Congestion Post Nasal Drip Sinusitis Asthma Diarrhea Fatigue

Pre-menstrual Syndrome Fibromyalgia Headache Watery Eyes Eczema/Atopic Dermatitis

Irritable Bowel Syndrome Itchy Eyes Skin Rash Vertigo Tinnitus Meniere's Disease

Other Symptoms: _____

*If you circled any of the symptoms listed above, please complete the rest of the questionnaire.

Family History of Allergy: Mother Father Brother/Sister Child None

Age symptoms began: Age 1-3 Age 3-12 before age 20 after age 20

My symptoms are worse: Spring Summer Fall Winter

Symptoms are present: 2-4 weeks 1-3 months 3-5 months Year Round

Allergic Triggers: House/Dust Mites Grasses Weeds Trees Molds/Yeast Cats Dogs Foods

Other _____

Non-allergic Triggers: Tobacco Smoke Pot Pouri Home Cleaning Supplies Gas/Diesel Fumes

Cold Air Heat/Humidity Barometric Changes Medications Perfumes

Other _____

I have been allergy tested before and found to be allergic to:

House/Dust Mites Trees Grasses Weeds Molds Cats Dogs Other _____

I was tested by: Skin Tests RAST ImmunoCap Other Blood Test

Asthma: I take medication for asthma. True☐ False☐

My asthma is: Mild☐ Moderate☐ Severe ☐

I had asthma in the past but "out grew" it. True☐ False ☐

I have never had asthma. True ☐ False☐

History of severe reactions or anaphylaxis:

Never☐ Bee or Wasp Stings☐ Shellfish☐ Peanuts☐ Other Foods☐ Medications☐ Other _____

Medications I have used for my nasal symptoms:

Oral Antihistamines☐ Decongestants (oral or nasal spray)☐ Cromolyn☐ Singulair☐ Nasal Steroids☐

Atrovent☐ Antihistamine nasal sprays☐ Other _____

I am allergic to: Milk and Milk products☐ Wheat☐ Corn ☐ Yeast☐ Soy ☐

Other Foods _____

Current Medical Illnesses: None☐ Heart☐ Lung☐ Kidney Disease☐ Skin☐ IBS☐ Diabetes ☐

Autoimmune Disease☐ Sinusitis☐ Otitis☐ Other _____

Please list all medications you are currently taking, including vitamins, hormones, over the counter drugs and herbal supplements.

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

I am interested in being allergy tested for:

Plants☐ Pollens☐ Molds☐ Animal Dander☐ Dust Mites☐ Foods☐ All ☐

I am interested in ***Allergy Drops*** to control my allergies. Yes☐ No☐

Name of person completing this form _____ Relationship to patient _____

Signature: _____ Date: _____