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ALLERGY HISTORY

Date:

Patient's Name: Last First Initial City State Zip
Sex Age
Home Telephone No. Area Code Number Parent's Name Last First Initial

To be filled out by patient Your answers to the following questions will help to determine the cause of your allergy symptoms. It is important to check (✓) each question as accurately as possible.

Have trouble with your skin?
Eczema
Hives

Have trouble with your ears?
Popping
Itching
Hearing loss
Fluid in ears
Infection/Pain

Have trouble with your throat?
Frequently sore/drainage
Itching throat/mouth

Have trouble with your eyes?
Redness
Itching
Tearing
Puffiness

Have trouble with your nose?
Clear/colorless discharge
Thick/colored discharge
Nasal itching/rubbing
Constant stuffiness
Periodic stuffiness
Sniffles
Sneezing
Mouth breathing or snoring

Have troubles with your chest?
Wheezing with colds
Wheezing when exposed to dust, pollen, animal, etc.
Wheeze/cough/after exercise
Cough? What kind?
Deep/or productive
Loose
Constant
Dry/tight
Daytime
Nighttime

Are your symptoms mild?
Moderate
Severe
Present most of the time
Present part of the time
Present rarely
Interfering with your life
Preventing many normal activities

Which of the following do you think cause your symptoms or make them worse?
Indoors
Outdoors
At home
At work
Morning
Afternoon
At night
Weather change
Wet weather
Dry weather
Windy day
Hot day
Cold day
Air conditioning
In barns
Damp areas
Hay, circus
Mowing lawn
Dusty environment
High air pollution
Animals
Cooking odors
Smoke
Soap powder
Insecticides
Paint fumes
Perfumes
Cosmetics
Wave sets
Newspapers
Wool
Road dust
Milk or milk products
Eggs
Wheat products
Nuts, beans, or seeds
Chocolate
Fish
Meat
Fruit
Vegetables
Alcoholic beverages
Cheese, mushrooms
Beer
Wine
Aspirin
Chemicals (list):
Drugs (list):

During what months do you usually have symptoms?
All months
January
February
March
April
May
June
July
August
September
October
November
December

Describe what symptoms bother you most

When did your condition begin?

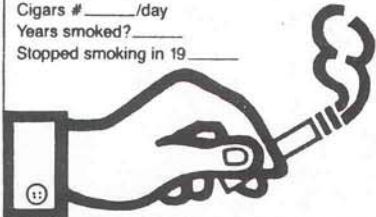
Do you use medication regularly for nasal symptoms?

What medication?
Does it help?

Do any of your blood relatives have allergies?
Have you ever had skin tests for allergies?
Do you have allergies?
What are you allergic to?

Is there anything else about your problem which you think might be important or unusual?

	YES	NO	Don't Know
Smokers in your home?			
Do you smoke?			
Cigarettes # _____/day			
Pipe # _____/day			
Cigars # _____/day			
Years smoked? _____			
Stopped smoking in 19 _____			



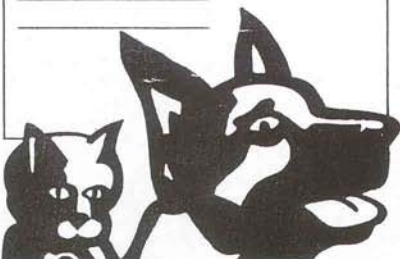
	YES	NO	Don't Know
Do you take medications daily or frequently?			
Aspirin			
Cortisone			
Laxatives			
Sedatives			
Birth control pills			
Vitamins			
Ointments			
Nose drops/sprays			
Hormones			
Others (list):			

	YES	NO	Don't Know
Do you spend a good deal of time in activities?			
Photography			
Carpentry			
Camping			
Sewing			
Gardening			
Painting			
Cooking			
Movies			
Hobbies (list):			

Sports (list):			

Other (list):			

	YES	NO	Don't Know
Do you have animals in your home?			
Have you ever had animals in your home?			
Dog			
Cat			
Bird			
Rodent			
Other (list):			



	YES	NO	Don't Know
Do you live in: House?			
Apartment?			
In the city?			
In the suburbs?			
Is your dwelling: New?			
3-10 years old?			
11-25 years old?			
> 25 years old?			

	YES	NO	Don't Know
Have you had any of the following?			
High blood pressure			
Migraine headaches			
Skin disease			
Heart disease			
Frequent headaches			
Sinus disease			
Stomach disease			
Asthma			
Nasal polyps			
Emphysema			
Broken nose			
Overactive thyroid			
Bronchitis			
Nasal surgery			
Underactive thyroid			
Hay fever			
Deviated septum			
Hormonal difficulty			
Hives			
Food allergy			
Drug allergy (describe):			

	YES	NO	Don't Know
Other conditions (describe):			

	YES	NO	Don't Know
Are you taking medication for any of the previous conditions? (describe):			

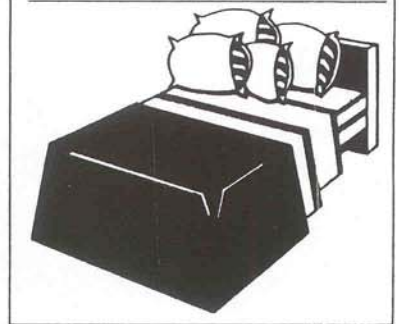
	YES	NO	Don't Know
Do you think your occupation has anything to do with your symptoms?			
Describe your occupation:			

	YES	NO	Don't Know
Are any materials used in your occupation that you think have something to do with your condition? (describe):			

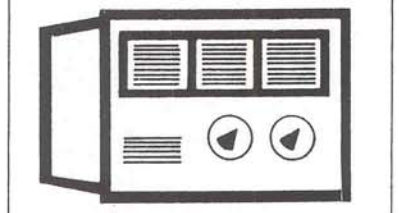
	YES	NO	Don't Know
At work, are your symptoms better?			
Worse			
The same			

	YES	NO	Don't Know
Do you sleep with a pillow?			
Is it dacron?			
Is it foam rubber?			
Is it feather?			
Other (describe):			

Is your mattress cotton?			
Feather			
Foam rubber			
Horse hair			
Other (describe):			



	YES	NO	Don't Know
Do you use a humidifier?			
Do you have an air conditioner?			
At work			
At home			
In bedroom			
Central			



	YES	NO	Don't Know
Is your heating system oil?			
Gas			
Coal			
Electric			
Other (describe):			

	YES	NO	Don't Know
Is heat delivered by blower?			
Radiators			
Electric panels			
Other (describe):			

