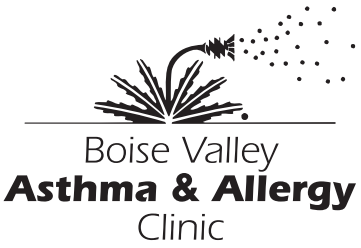
ALLERGY AND ASTHMA HISTORY



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Satellite Clinics: Eagle, Nampa, & Caldwell

Name _____

Date _____ Date of Birth _____ Age _____

Phone: Home _____ Work _____ Sex M / F _____

Cell: _____ Email: _____

Address _____

City, State, Zip _____

Occupation / grade level _____

Primary Care Clinician _____

Pharmacy _____

Referral source (MD, NP, phone book, internet, insurance, other) _____

The main reasons for coming here are:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

At what age did this first occur? _____

ALLERGY TO INSECT STINGS/Does not include other bug bites

❑ **Yes** ❑ **No** (If no go to the next section)

❑ Local reaction
❑ Hives
❑ Cough/wheezing
❑ Loss of consciousness/light headed
❑ Large Swelling
❑ Other: _____

Suspected insect:

❑ Honey bee
❑ Hornet
❑ Other
❑ Yellow Jacket
❑ Wasp
❑ Fire Ants

Site of sting: _____
Onset of symptoms: _____
Duration of symptoms: _____
Medications used: _____

All current medicines: (please include all inhalers & sprays, as well as any herbs/supplements/alternative medicines and CPAP)

Medication	Please include dose:			Physicians Notes
_____	_____	_____	times per day	_____
_____	_____	_____	times per day	_____
_____	_____	_____	times per day	_____
_____	_____	_____	times per day	_____
_____	_____	_____	times per day	_____
_____	_____	_____	times per day	_____
_____	_____	_____	times per day	_____
_____	_____	_____	times per day	_____
_____	_____	_____	times per day	_____

Please list all medications that you have taken in the last two years.

Asthma medication you have used in the past:_____Antihistamines used in the past:_____

Nasal sprays used in the past:_____Eyedrops used in the past:_____

Current environment:

Age of home: _____ Number of rooms: _____ Time at current residence:_____

Animals	❑ **YES**	❑ **NO**
Outdoor cat now	❑	
Indoor cat now	❑	
Indoor cat in the past	❑	
Outdoor dog now	❑	
Indoor dog now	❑	
Indoor dog in the past	❑	
Birds now or in past	❑	
Other animals		

Humidity Problems	❑ **YES**	❑ **NO**
Moisture water damage	❑	
Mold growth	❑	

Other Triggers	❑ **YES**	❑ **NO**
Time in daycare	❑	
Animals in daycare	❑	
Latex/rubber exposure	❑	

Is there anything in your home or at work that triggers your allergies or asthma?_____

_____

_____

Previous residences:

City, State	from:	to:	City, State	from:	to:
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Past Allergy and Asthma History :

	YES	NO
Have you had previous allergy testing?	❑	❑

If you answered yes, then please answer the following questions:

	YES	NO		YES	NO
Previous allergy shots?	❑	❑	Still on allergy shots?	❑	❑
Allergy shots have helped?	❑	❑	Frequency of allergy shots _____		
Any minor reactions?	❑	❑	Previous chest x-ray?	❑	❑

If you have had any major reactions, please describe? _____

Past Medical History:

Chronic Health Conditions

- ❑ High blood presure
- ❑ Heart disease
- ❑ Thyroid
- ❑ Diabetes
- ❑ Other:_____

_____

_____

Surgery:

- ❑ Appendectomy
- ❑ C-Section
- ❑ Hysterectomy
- ❑ Ear tubes
- ❑ Sinus
- ❑ Tonsils
- ❑ Adenoids
- ❑ Gallbladder

❑ Other:_____

_____

_____

Recent emergency visits last two years:_____

_____

Immunization Adverse Reactions ❑ **Yes** ❑ **No**

Influenza shot this year ❑ **Yes** ❑ **No** **When:**_____ **Prevnar shot** ❑ **Yes** ❑ **No** **When:**_____

Pneumonia shot ❑ **Yes** ❑ **No** **When:**_____ **Are immunizations up to date** ❑ **Yes** ❑ **No** **When:**_____

Drug Allergies

Drug		*Symptom*	*Drug*		*Symptom*
_____	caused	_____	_____	caused	_____
_____	caused	_____	_____	caused	_____

FAMILY HISTORY:

	Nasal Allergies	Asthma	Food Allergies	Eczema	Emphysema	Hives
Father:	❑	❑	❑	❑	❑	❑
Mother	❑	❑	❑	❑	❑	❑
Brother(s):	❑	❑	❑	❑	❑	❑
Sister(s)	❑	❑	❑	❑	❑	❑
Children	❑	❑	❑	❑	❑	❑
Extended Family	❑	❑	❑	❑	❑	❑

Family history of severe infections, unexplained deaths, cystic fibrosis, lupus, thyroid disease, celiac/gluten or rheumatoid arthritis? ❑ **YES** ❑ **NO**

SOCIAL HISTORY:

Primary residence is: ❑ one home
❑ split between homes

Number of individuals in the household: _____

Current occupation/grade level (if student): _____

Preschool or Daycare: Yes ❑ No ❑

School/work loss from asthma/nasal symptoms: Yes ❑ No ❑

Do you have medical insurance: Yes ❑ No ❑

Other relevant social factors: _____

What are your hobbies and interests outside of work, school and family?

_____

Habits:	**YES**	**NO**
Alcohol consumption	❑	❑_____ drinks per week
Smoking currently	❑	❑ For _____ years ___ ppd
Smoking in past	❑	❑ For _____ years ___ ppd
Electronic Cigarettes (Vaping)	❑	❑
Marijuana use	❑	❑

REVIEW OF SYSTEMS: (check all that apply to you)

General
- ❑ Fatigue/localized weakness
- ❑ Fever/chills
- ❑ Hot flashes
- ❑ Night sweats
- ❑ Unexplained weight loss
  Weight gain

SKIN
- ❑ Rash
- ❑ Wounds or Sores
- ❑ Swelling of the lips/face

SleepApnea
- ❑ Loud snoring
- ❑ Interrupted breathing during sleep
- ❑ Using CPAP

Cardiac
- ❑ Chest pain
- ❑ Palpitations
- ❑ Leg swelling
- ❑ Other heart condition:_____

GI
- ❑ Food getting stuck in throat
- ❑ Heartburn/reflux
- ❑ Abdominal pain
- ❑ Nausea/vomiting
- ❑ Diarrhea/constipation
- ❑ Liver disease

GU
- ❑ Painful urination
- ❑ Blood in the urine

Hematologic
- ❑ Swollen lymph nodes
- ❑ Anemia

Endocrine
- ❑ Hot intolerance
- ❑ Cold intolerance
- ❑ Diabetes/Pre-Diabetes
- ❑ Thyroid Problems

Neuro
- ❑ Memory problems
- ❑ Headache
- ❑ Numbness
- ❑ Dizziness/Vertigo
- ❑ Problems with balance

Musculo/skeletal
- ❑ Joint pain/muscle pain
- ❑ Joint swelling

Psychiatric
- ❑ Depression
- ❑ Anxiety
- ❑ Other psychiatric condition

Physician Notes:

Name of person filling out this history form (print):_____

Relationship to patient if not the patient:_____