HEALTHCARE CENTERS
of MORRIS HOSPITAL

ALLERGY HISTORY:

Reason for your visit today: _____

_____

_____

Were you referred by a physician to see an allergist? If yes, please provide the providers name, office phone and fax number: _____

_____

WHAT ARE SOME OF THE TRIGGERS FOR YOUR SYMPTOMS

(Please check all items or triggers that you feel make your symptoms worse):

OUTDOOR:

☐ barn exposure ☐ being around flowers/plants ☐ bird ☐ bonfire ☐ burning leaves ☐ fall ☐ farm area ☐ fireplace ☐ grass ☐ hay ☐ hornet ☐ horses ☐ lakes/retention ponds ☐ mold/mildew ☐ mosquito bite ☐ mowing grass ☐ outdoor smoke ☐ pollen ☐ raking leaves ☐ spider bite ☐ spring ☐ stinging insect bite ☐ summer ☐ swimming pool ☐ trees ☐ wasp ☐ weeds ☐ winter

INDOOR:

☐ air-conditioning ☐ aromatic wood/incense ☐ basement ☐ bedroom ☐ carpet ☐ cat ☐ comforter ☐ dog ☐ fabric/upholstery furniture ☐ guinea pig ☐ hamster ☐ home ☐ house cleaning ☐ house dust ☐ mattress ☐ other animals ☐ school ☐ stuffed animals ☐ vacuuming ☐ ventilation ☐ work environment

CHEMICAL/CLOTHING:

☐ adhesive ☐ aerosol products ☐ air freshener ☐ blanket ☐ bleach/chlorinated products ☐ cashmere ☐ chalk ☐ detergents ☐ down coat ☐ dry-cleaned garments ☐ fabric dyes/coloring ☐ feather pillows/bedding ☐ fertilizer ☐ fiberglass ☐ glue ☐ household cleaners ☐ industrial solvents ☐ insecticide ☐ new clothing ☐ nylon ☐ old clothing ☐ paint fumes/thinners ☐ paper boxes ☐ polyester ☐ rubber ☐ sawdust ☐ shoes ☐ socks ☐ spandex ☐ tight garments ☐ undergarments ☐ waist/elastic band ☐ wool

DIRECT CONTACT:

☐ acrylic nails ☐ alcohol based body/facial products ☐ anti-aging products ☐ bath oils ☐ body soaps ☐ bronze ☐ cosmetics ☐ deodorants ☐ dishwashing soap ☐ eye cream ☐ fabric softener/sheets ☐ face wash ☐ hair dye ☐ jewelry ☐ latex ☐ laundry detergent ☐ leather belt ☐ lotions ☐ metal wrist watch ☐ metallic implants ☐ mouthwash ☐ nail polish ☐ nail polish remover ☐ newspaper ☐ nickel ☐ perfumes ☐ scented hygiene products ☐ shampoo/conditioner ☐ shaving cream/gel ☐ silver ☐ tin ☐ titanium ☐ toothpaste

NON-ALLERGY RELATED:

☐ anger ☐ cold air ☐ cold beverage ☐ cold object ☐ cold water ☐ cooking fumes/odors ☐ direct pressure on skin ☐ dry air ☐ emotional stress ☐ exercise ☐ gardening products/sprays ☐ going from hot to cold temperature ☐ heat ☐ hot beverage/foods ☐ hot water/shower ☐ humidity ☐ minor trauma to skin ☐ pollution ☐ prolonged sitting ☐ rain ☐ rubbing skin ☐ sauna ☐ sleeping on back ☐ spicy foods ☐ sweating ☐ tobacco smoke ☐ travelling ☐ vapors ☐ vibration ☐ while cooking ☐ while eating

FOOD:

☐ aged cheese ☐ banana ☐ beef ☐ beer ☐ berries ☐ bread ☐ buckwheat ☐ caffeine products ☐ cakes ☐ celery ☐ cereal ☐ cheese ☐ chocolate ☐ cider ☐ citrus ☐ coffee ☐ cooking oils ☐ corn ☐ corn syrup ☐ cured meats ☐ dried fruit ☐ eggs ☐ fish ☐ food dyes ☐ fresh fruit ☐ fresh vegetables ☐ frozen food products ☐ gluten ☐ ham ☐ herbs ☐ ketchup ☐ lamb ☐ malic acid ☐ melons ☐ milk ☐ mint ☐ mixed alcoholic beverages ☐ MSG ☐ nuts ☐ oats ☐ peanut ☐ pears ☐ pickles ☐ pork ☐ potatoes ☐ processed meats ☐ rye ☐ sausage ☐ shellfish ☐ soy ☐ spices ☐ starch ☐ tea ☐ tomatoes ☐ turkey ☐ vinegar ☐ wheat ☐ wine

HORMONAL (women only):

☐ hives during pregnancy ☐ hives during menstrual cycle ☐ irregular periods

☐ **I am not experiencing any of the above symptoms at this time**

Please explain any of the above checked triggers in detail (if needed) or please include any triggers not mentioned above which may be causing a problem for you: _____

_____

PRIOR ALLERGY HISTORY:

Have you been evaluated by an allergist in the past? ☐ yes ☐ no

Have you ever been diagnosed with any of the following conditions: ☐ yes (*check all that apply*) ☐ no

☐ allergic reaction ☐ allergy rhinitis/allergies seasonal ☐ anaphylaxis (life-threatening allergy reaction) ☐ angioedema (swelling of the face, lips, mouth, hands or feet) ☐ asthma ☐ celiac disease ☐ chronic hives ☐ contact dermatitis ☐ dermatographism (skin writing disease) ☐ drug allergy ☐ eczema/atopic dermatitis ☐ exercise-induced asthma ☐ food allergies ☐ food intolerance ☐ immunodeficiency ☐ itchy skin ☐ lactose intolerance ☐ low antibody levels ☐ non-allergic rhinitis or weather induced allergies ☐ pet allergies ☐ year-round allergies ☐ other: _____

Have you had prior testing? ☐ yes (*check all that apply*) ☐ no

☐ antibiotic testing ☐ food allergy testing ☐ insect sting testing ☐ patch testing ☐ PFT or spirometry testing ☐ RAST/immunocap testing (blood test for allergies) ☐ skin testing

Please explain any important findings from above prior testing: _____

Have you had any prior treatment? ☐ yes (*check all that apply*) ☐ no

☐ avoidance measures ☐ dustmite control measures ☐ eczema treatment ☐ epipen/epinephrine auto-injector

☐ food allergy treatment ☐ hives workup and treatment ☐ OTC/prescription medication ☐ SLIT (oral allergy drops)

Have you received allergy injections in the past? ☐ yes ☐ no *If yes, when:* _____

Result of allergy injections: ☐ allergic reaction to allergy injections ☐ symptoms alleviated ☐ symptoms not alleviated

Do you have any diagnosed food allergies? ☐ yes ☐ no

If yes, please list all foods you are allergic to and the reaction you had to that particular food:

Food: _____ Reaction: _____

Food: _____ Reaction: _____

Food: _____ Reaction: _____

Food: _____ Reaction: _____

Do you avoid any foods? ☐ yes ☐ no

If yes, please list any foods you are avoiding: _____

PEDIATRIC ALLERGY HISTORY *(for all ages 6-12)***:**

History of any of the following: ☐ yes (*check all that apply*) ☐ no

☐ chronic congestion or runny nose ☐ colic ☐ croup ☐ difficulty with feeding ☐ eczema ☐ failure to thrive

☐ food allergies ☐ hay fever ☐ history of FPIES (vomiting/bloody stools) ☐ low birth weight ☐ milk intolerance

☐ pneumonia(s) ☐ premature birth ☐ recurrent viral infections and colds ☐ reflux ☐ RSV infection ☐ wheezing

Were you breastfed? ☐ yes ☐ no *If yes, how long*: _____

Were you formula fed? ☐ yes ☐ no I*f yes, how long*: _____

Have you had reactions or did not tolerate immunizations? ☐ yes ☐ no

Are you up to date on immunizations? ☐ yes ☐ no

ENVIRONMENTAL HISTORY:

How long have you lived in your residence? ☐ < 1 year ☐ 1-5 years ☐ 6-10 years ☐ > 10 years

Type of home? ☐ house (basement) ☐ garden-level apartment/duplex ☐ single family home – own

☐ single family home – rent ☐ townhouse ☐ upper-level apartment/duplex

Age of home? ☐ < 1 year ☐ 1-5 years ☐ 6-10 years ☐ 10-20 years ☐ > 20 years

Location of home? ☐ city ☐ rural area ☐ suburbs

Do you have a basement? ☐ yes (*check all that apply*) ☐ no

☐ crawl space ☐ dry ☐ finished ☐ unfinished ☐ seepage or leak ☐ wet or musty

Past flooding in the home? ☐ yes ☐ no ☐ unknown

Type of heating in home? ☐ central forced air ☐ hot air ☐ hot water (baseboard) ☐ radiator (steam) ☐ solar

☐ space/electric heater

Type of air-conditioning? ☐ none ☐ central A/C ☐ window unit ☐ other _____

Change air filters? ☐ every month ☐ every 3 months ☐ every 6 months ☐ never ☐ unknown

Type of filters? ☐ HEPA ☐ 3M ☐ 2M ☐ unknown

Do you keep your windows open in warmer months? ☐ yes ☐ no

Type of home ventilation? ☐ air cleaner ☐ ceiling fans ☐ dehumidifier ☐ HEPA filters ☐ humidifier

☐ wood/coal stove or fireplace

Number of pets? ☐ 1 ☐ 2 ☐ 3 or more

☐ cats ☐ dogs ☐ birds ☐ guinea pigs ☐ hamsters ☐ rabbits ☐ other animal(s) _____

Do pets sleep in your bedroom? ☐ yes ☐ no

Are there any tobacco smokers in the home? ☐ yes ☐ no

Is your bedroom in the basement? ☐ yes ☐ no

Do you use allergy-proof encasing for your pillows and/or comforter? ☐ yes ☐ no ☐ unknown

Do you use feather pillows and/or comforter? ☐ yes ☐ no ☐ unknown

Type of flooring in your bedroom? ☐ animal skin ☐ area rug ☐ bare floor ☐ wall to wall carpet

Age of carpeting in bedroom? ☐ < 1 year ☐ 1-5 years ☐ 6-10 years ☐ > 10 years ☐ unknown

Carpeting in the living room? ☐ yes ☐ no

Age of mattress? ☐ < 1 year ☐ 1-5 years ☐ 6-10 years ☐ > 10 years ☐ unknown

What is inside your mattress? ☐ cotton ☐ foam ☐ unknown

Problems with roaches or mice in your home? ☐ yes ☐ no ☐ unknown

Problems with water leaks or mold contamination in your home? ☐ yes ☐ no ☐ unknown

Is your residence excessively humid? ☐ yes ☐ no ☐ unknown

PRIOR LAB WORK, TESTING OR CONSULTATIONS:

Have you had any prior autoimmune workup checking for rheumatologic conditions in the past? ☐ yes ☐ no

Have you had any prior testing/imaging: ☐ yes (*check all that apply*) ☐ no

☐ chest xray ☐ CT of chest ☐ CT of ear ☐ CT of head ☐ CT of neck ☐ CT of sinuses ☐ endoscopy with biopsy

☐ MRI of ear ☐ MRI of head ☐ MRI of neck ☐ MRI of sinuses ☐ prior sinus surgeries ☐ rhinoscope ☐ skin biopsy

Have you had any prior consultations: ☐ yes (*check all that apply*) ☐ no

☐ ENT ☐ dermatology ☐ gastroenterology ☐ pulmonary ☐ rheumatology

Please describe all important lab, imaging and consultation findings from above: _____

_____

_____

_____

NASAL OR SINUS CONCERNS *(if none, please skip to the next section)*:

Do you have the following nasal or sinus symptoms consistently? ☐ yes (*check all that apply*) ☐ no

☐ burning in mouth ☐ clear, thin/think or white/yellow/green mucous ☐ congestion ☐ dark circles under eyes

☐ dry mouth ☐ dry/gritty eyes ☐ ear pain ☐ ear plugging ☐ ear ringing ☐ hayfever ☐ headache ☐ hoarseness

☐ itchy mouth or lips ☐ migraines ☐ nasal polyps ☐ nasal/sinus pressure ☐ pain in throat ☐ postnasal drip

☐ red eyes ☐ runny nose ☐ scratchy throat ☐ sneezing ☐ sores in mouth ☐ watery eyes

How long have you been having symptoms? _____

Describe your symptoms:

☐ no pattern noticed ☐ ongoing for #_____ days, months, years ☐ daily ☐ intermittent ☐ worse in morning

☐ worse in afternoon ☐ worse in evening ☐ worst at night ☐ specific pattern, please describe: _____

What medications have you tried as treatment for nasal or sinus problems and how long (*Please list name, dose, and duration of treatment*)? _____

_____

Did the treatment work? ☐ yes ☐ no

Please list all over the counter and prescription allergy and sinus medications taken: _____

_____

Are there any other important details about your nasal or sinus problems that you think we should know? _____

_____

ASTHMA OR BREATHING CONCERNS *(if none, please skip to the next section)*:

At what age were you first diagnosed with asthma? _____

How was the asthma diagnosed? _____ ☐ unknown

Do you have the following breathing or asthma symptoms consistently? ☐ yes (*check all that apply*) ☐ no

☐ anxiety ☐ burning in chest ☐ chest pain with exhalation ☐ chest pain with inhalation ☐ chest tightness

☐ cold hands and feet ☐ cyanosis ☐ cough – dry, hacking ☐ cough – productive ☐ fatigue ☐ feeling of warmth

☐ hyperventilation ☐ mucous production ☐ nervousness ☐ numbness and tingling in hands or feet ☐ pain in back

☐ pain in ribs ☐ pain in shoulder ☐ shortness of breath ☐ wheezing – persistent, intermittent

Describe all that apply to the pattern and duration of your asthma or breathing problems:

☐ no pattern found ☐ rare and mild ☐ getting worse ☐ about the same ☐ at rest ☐ exertion ☐ morning

☐ afternoon ☐ evening ☐ throughout the day ☐ intermittent ☐ continual ☐ 1-2 times a week

☐ more than twice a week ☐ few times a month ☐ wakes patient up at least once a week at night

☐ wakes up patient more than once at night ☐ spring ☐ summer ☐ fall ☐ winter ☐ year round

How often do your symptoms occur?

☐ # _____ per week ☐ # of _____ nighttime awakenings ☐ # _____ per month

How many times a year do the following infections make your asthma or breathing worse?

☐ # of bronchitis _____ ☐ # of pneumonias _____ ☐ # of recurrent URIs _____ ☐ # of sinus infections _____

How many urgent care/ER visits have you had for asthma or breathing trouble in the past year? _____

How many oral or IV steroid courses for asthma in past year? _____

Were the symptoms alleviated with steroids? ☐ yes ☐ no

Number of days missed from work or school in past year? _____

Number of infections triggering asthma in past year? _____

Do you have an Asthma Action Plan given by a health care provider in the past year? ☐ yes ☐ no

When was your last PFT or spirometry? _____

When was your last Chest X-ray or CT of chest? _____

Have you ever been treated with inhalers? ☐ yes ☐ no

What inhalers have you tried in the past and what are you currently using if prescribed something for breathing issues (or asthma)? List name of all inhalers, dose and how often you are using it? _____

_____

Of the inhaler(s) you are currently using or were given in the past, which have helped your breathing? List names: _____

_____

RECURRENT INFECTIONS *(if you have had 9-12 diagnosed infections in the past year, then please complete this section)***:**

How long have you been getting recurring infections? _____

How many days have you missed from work or school due to recurrent infections in the past year? _____

What symptoms do you have with these recurrent infections?

☐ anemia ☐ bruising ☐ chest tightness ☐ chronic congestion ☐ chronic runny nose ☐ clear mucous drainage

☐ cold or heat intolerance ☐ dry cough ☐ ear pain and ringing ☐ headaches ☐ itchy eyes ☐ loss of appetite

☐ nasal polyps ☐ night sweats ☐ ocular tearing ☐ productive cough ☐ purple skin rash ☐ shortness of breath

☐ sore throat ☐ swollen eyes ☐ weight loss ☐ wheezing ☐ yellow or green mucous

What types of recurrent infections have you had in the past years? (*occurring at lease 6-8 times per year*)

☐ bronchitis ☐ ear infections ☐ pneumonia ☐ skin infections ☐ sinusitis ☐ upper respiratory infections

Have you done the following activities in the past 1-2 years before your infections started? ☐ yes ☐ no

☐ camping ☐ drinking unpasteurized milk products ☐ drinking water from fresh stream

☐ food consumption at picnic ☐ travel outside the country ☐ wooded areas

Have you received any of the following treatment for your immune system? ☐ yes ☐ no

☐ abscess drainage ☐ allergy injections ☐ antibiotics ☐ oral steroids ☐ IV steroids ☐ IVIG ☐ sinus surgery

List the name of all medications you have tried for recurrent infections (include all antibiotics): _____

_____

Are you on IVIG treatment? ☐ yes ☐ no I*f yes, what is the name of the medication and how long were you treated?*

_____

Did the treatment work? ☐ yes ☐ no

ALLERGIC REACTION, SWELLING, AND SKIN RASHES *(if none, please skip this section)***:**

Are you having any of the current skin problems or reactions? ☐ yes ☐ no

☐ anaphylactic/severe allergic reaction ☐ chronic itching ☐ eczema/atopic dermatitis ☐ hives ☐ rash ☐ swelling

At what age were you first diagnosed with skin problem or allergic reaction(s)? _____

Describe the characteristics of the current skin reaction(s) or rash: _____

Where is the skin rash or allergic reaction occurring? (*check all that apply*)

☐ abdomen ☐ all over body ☐ ankle ☐ arms ☐ around eyes ☐ back ☐ chest ☐ eyebrow area ☐ face ☐ feet

☐ fingers ☐ groin ☐ hands ☐ legs ☐ lips ☐ neck ☐ on eyelids ☐ spreading everywhere ☐ throat ☐ trunk

☐ wrist

Describe the pattern of the allergic reaction (*check all that apply*):

☐ no pattern found ☐ getting worse ☐ getting better ☐ intermittent ☐ lasts 12 hours ☐ lasts 24 hours

☐ lasts 2-6 hours ☐ lasts greater than 6 hours ☐ lasts less than 1 hour ☐ lasts more than 24 hours ☐ occurring at night

☐ occurring in the afternoon ☐ occurring in the evening ☐ occurring in the morning ☐ occurring once a day

☐ occurring through the day ☐ present all the time ☐ resolved ☐ same ☐ sporadic

☐ wakes me up at night

Did food avoidance alleviate skin condition? ☐ yes ☐ no *If yes, please list foods:* _____

How many ER/urgent care visits have you had for skin rash or allergic reactions in the past 6 months?

Have you used any of the following medications on a regular basis in past year? ☐ yes (*check all that apply*) ☐ no

☐ antidepressant ☐ arthritis medication ☐ aspirin/nonsteroidal medication (motrin/ibuprofen) ☐ biologics ☐ bioxin

☐ blood pressure medication ☐ cephalosporin ☐ cholesterol medication ☐ cortisone ☐ cough medication

☐ decongestants ☐ diet pills ☐ digitalis ☐ diuretics ☐ erythromycin ☐ floroquinolone ☐ homeopathic/herbal

☐ supplements ☐ hormones ☐ insulin ☐ IV contrast media ☐ laxatives ☐ mouth washes ☐ muscle relaxants

☐ narcotics ☐ oral contraceptives ☐ PCN ☐ sedatives ☐ seizure medication ☐ sulfa ☐ suppositories ☐ tetracycline

☐ thyroid medication ☐ tonic or quinine ☐ tranquilizers ☐ vaccination ☐ vitamins ☐ water pill ☐ zithromycin

☐ other: _____

Do you think a particular medication(s) may be causing your symptoms? ☐ yes ☐ no *If yes, list medication(s):* _____

_____

Were any of your current medication that were just started in the past 1 year or has the dose changed within the past 6 months? ☐ yes ☐ no *If yes, list name of medication(s)* _____

_____

Please list all treatments tried for your skin rash or allergic reaction:

☐ antibiotics ☐ avoidance of triggers ☐ Benadryl liquid ☐ Benadryl oral ☐ Claritin/loratidine ☐ allegra/fexofenadine

☐ cetirizine/Zyrtec ☐ hydroxyzine/atarax ☐ pepcid/famotidine ☐ zantac/ranitidine ☐ singulair

☐ others _____ (list name and dose used)

☐ changed all body products ☐ changed detergent brand ☐ Epinephrine given in ER ☐ Epipen/Auvi-Q for home

☐ fragrance-free detergents ☐ hypoallergenic soaps ☐ itching ☐ IV steroids were given ☐ lotions ☐ moisturizers

☐ oral steroids ☐ OTC/prescription creams/ointments ☐ shampoos ☐ other: _____

Did the treatment work? ☐ yes ☐ no

FOOD REACTION *(if none, please skip this section)***:**

List all foods which you already have a confirmed diagnosis of a food allergy and describe the reaction you had: _____

_____

_____

Do you have the following symptoms from Food Ingestion consistently? ☐ yes (*check all that apply*) ☐ no

☐ abdominal pain ☐ anaphylaxis ☐ bloating ☐ blood in stool ☐ burning in mouth ☐ chest tightness ☐ congestion

☐ constipation ☐ coughing ☐ diarrhea ☐ diffuse hives ☐ dizziness ☐ eczema/atopic dermatitis ☐ flushing ☐ gas

☐ headaches ☐ itchy mouth/lips ☐ joint pain ☐ localized hives ☐ loose stools☐ loss of consciousness ☐ migraines

☐ muscle stiffness/pain ☐ nausea ☐ numbness/tingling ☐ rashes ☐ runny nose ☐ shortness of breath

☐ skin itching ☐ sneezing ☐ sores in mouth ☐ stomach cramping ☐ swelling ☐ vomiting ☐ watery/itchy eyes

☐ wheezing

Duration/pattern of symptoms: ☐ _____ # of days ☐ _____ # of months ☐ _____ # of years ☐ daily ☐ intermittent

☐ worse in morning ☐ worse in afternoon ☐ worse in evening ☐ worse at night ☐ no pattern

☐ specific pattern: _____

Did avoidance of certain foods above alleviate yours symptoms? ☐ yes ☐ no ☐ not sure

Do you have a milk allergy or are you lactose intolerant? ☐ yes ☐ no *If yes, at what age did it occur?* _____

Do you have diagnosed gluten intolerance? ☐ yes ☐ no *If yes, at what age did it occur?* _____

Please list all treatments tried for your food allergy/intolerance (*check all that apply*):

☐ no treatment in the past ☐ albuterol ☐ antihistamine – as needed ☐ antihistamine – daily ☐ Epinephrine in ER

☐ Epipen/Auvi-Q at home ☐ IV steroids ☐ medication along with food avoidance ☐ moisturizers for skin

☐ oral immunotherapy (SLIT) ☐ oral steroids ☐ steroid creams/ointments ☐ steroid inhaler

Did the treatment work? ☐ yes ☐ no

Are there any other important details that you think we should know? _____

_____

HEALTHCARE CENTERS
of MORRIS HOSPITAL

STINGING INSECT ALLERGY *(if none, please skip this section)***:**

Have you ever been stung by an insect? ☐ yes (*check all that apply*) ☐ no

☐ bee ☐ fire ant ☐ hornet ☐ mosquito ☐ spider ☐ wasp ☐ yellow jacket ☐ unknown

Did you have a reaction? ☐ yes (*check all that apply*) ☐ no

☐ anaphylactic shock ☐ asthma symptoms ☐ bloating ☐ chest tightness ☐ diarrhea ☐ eye swelling

☐ facial swelling ☐ flushing ☐ hives all over ☐ itching all over ☐ large but localized reaction ☐ lip swelling

☐ localized minor rash ☐ loss consciousness ☐ low blood pressure ☐ mild redness ☐ mild swelling ☐ nausea

☐ persistent coughing ☐ shortness of breath ☐ tongue swelling ☐ vomiting ☐ wheezing

How did you treat the reaction?

☐ antihistamine or Benedryl ☐ epinephrine given in ER ☐ ER/urgent care visit(s) ☐ Epinephrine/Auvi-Q at home

☐ nebulizer treatment ☐ topical Benadryl ☐ topical steroid cream/ointment ☐ O2 given

List any important details about the reaction: _____

_____

Please also let us know of any information that you feel is worth knowing regarding your current symptoms and medical history that we did not ask in this form: _____

_____

_____

I have provided all accurate information regarding my current symptoms and medical health to the best of my ability for my visit to the Allergist.

Patient Signature: _____ Date: _____