CornerStone
Sinus & Allergy Center
A Division of CornerStone Ear, Nose & Throat

Allergy Patient Medical History Form

PATIENT NAME: _____
DATE: _____

PLEASE INDICATE THE ANSWER TO EACH QUESTION BELOW AS IT PERTAINS TO THE ALLERGY PATIENT

Occurrence and Frequency of Allergy Symptoms

1: When are your symptoms most severe?
❑ *Spring* ❑ *Summer* ❑ *Fall* ❑ *Winter* ❑ *Year-round*

2: How long do your symptoms last?
❑ *A few minutes* ❑ *Several hours* ❑ *Several days*
❑ *An entire season* ❑ *Year-round*

3: Do your symptoms occur regularly at a particular time of day or night? ***Yes*** ***No***

4: Do your symptoms cause you to lose sleep? ***Yes*** ***No***

5: Do your symptoms interrupt your daily routine? ***Yes*** ***No***

6: Have you found any products which consistently relieve your symptoms? ***Yes*** ***No***

If yes, please list products: _____
_____

Childhood Allergies

7: As a child did you have:
(check all that apply)
❑ *Colic* ❑ *Eczema or chronic skin troubles*
❑ *Asthma* ❑ *Bronchitis*

8: As a child, did you suffer FREQUENTLY with:
(check all that apply)
❑ *Colds* ❑ *Stomachaches* ❑ *Ear infections*
❑ *Sore throats* ❑ *Sinus infections*

Family History

9: Do any members of your family suffer from:
(check all that apply)
❑ *Asthma* ❑ *Allergies* ❑ *Frequent headaches*
❑ *Eczema* ❑ *Migraines* ❑ *Chronic skin disease*
❑ *Bronchitis* ❑ *Hives* ❑ *Hay fever*

Environmental Factors

10: Do you notice allergy symptoms worsening when:
(check all that apply)
❑ *House cleaning* ❑ *Sweeping* ❑ *Making the bed*

11: Are allergy symptoms worse in buildings such as:
(check all that apply)
❑ *Theaters* ❑ *Churches* ❑ *Grocery stores*
❑ *Libraries* ❑ *Old homes* ❑ *Cellars/Sheds*
❑ *Basements* ❑ *Department stores*

12: Are allergy symptoms worse when:
(check all that apply)
❑ *Weather is wet or damp*
❑ *Grass is being mowed*
❑ *Weeds are being cut*
❑ *Hay or straw is present (barn, landscaping)*
❑ *You are in closets with old or unused leather*
❑ *You sit on overstuffed furniture*

13: Are allergy symptoms caused or worsened by:
(check all that apply)
❑ *Fatigue* ❑ *A change in the weather*
❑ *Excitement* ❑ *Air conditioning*
❑ *Exercise* ❑ *Emotional distress*
❑ *Stress* ❑ *Nervousness/anxiety*

14: Do you participate in any outdoor activities? ***Yes*** ***No***

15: Do you or anyone in your household smoke? ***Yes*** ***No***

Allergies In Work/School Environment

16: Is your work/school environment:
(check all that apply)
❑ *Dusty* ❑ *Cooled with attic/ceiling/window fans*
❑ *Moldy* ❑ *Air-conditioned*
❑ *Smoky*

17: Do you have allergy symptoms at work/ school? ***Yes*** ***No***

18: Are chemicals (insecticides, dyes, solvents, etc.) used at your work? ***Yes*** ***No***

19: Do you come in contact with grain dusts, animal feeds, paints, or sawdust? ***Yes*** ***No***

20: Are there fumes or heavy odors at your work or school? ***Yes*** ***No***

21: Do you inhale anything at work that might aggravate your symptoms? ***Yes*** ***No***

Animal Dander & Dust Mites

22: Do you handle or come in contact with animals or animal hairs at work? ***Yes*** ***No***

23: Are symptoms induced or aggravated by: (check all that apply)

❑ *Dogs* ❑ *Guinea pigs* ❑ *Parrots*
❑ *Cats* ❑ *Ducks* ❑ *Turkeys*
❑ *Horses* ❑ *Chickens* ❑ *Canaries*
❑ *Rabbits* ❑ *Pigeons* ❑ *Feather pillows*

24: Do you have difficulty if you handle: (check all that apply)

❑ *Furs* ❑ *Rugs* ❑ *Stuffed animals*
❑ *Gloves* ❑ *Hats* ❑ *Blankets*

General Allergy Questions

25: Have you ever been tested for allergies? ***Yes*** ***No***

26: Have you ever received allergy injections? ***Yes*** ***No***

27: Are you currently taking any allergy medications? ***Yes*** ***No***

If yes, please list the medications you are currently taking:

_____
_____
_____

28: Have any allergy treatments or medications provided prolonged relief? ***Yes*** ***No***

29: Have you ever required emergency treatment for an allergic reaction? ***Yes*** ***No***

30: Do you have difficulty exercising due to allergies or sinus conditions? ***Yes*** ***No***

31: Do you have difficulty sleeping or staying asleep? ***Yes*** ***No***

32: Are you frequently sick? ***Yes*** ***No***

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PLEASE INDICATE THE INTENSITY OF ALL ALLERGY SYMPTOMS YOU EXPERIENCE BY CIRCLING THE MOST ACCURATE RATING

A rating of 1 indicates the symptom is noticeable; a rating of 5 meaning the symptom is intolerable.

Nose

Itching	1	2	3	4	5
Sneezing	1	2	3	4	5
Congestion	1	2	3	4	5
Snoring	1	2	3	4	5
Drainage/post-nasal drip	1	2	3	4	5
Inability to breathe	1	2	3	4	5
Swelling	1	2	3	4	5
Frequent "colds"	1	2	3	4	5
Polyps	1	2	3	4	5
Sinus infections	1	2	3	4	5
Dryness	1	2	3	4	5
Foul odor	1	2	3	4	5
Nosebleeds	1	2	3	4	5

Eyes

Itching	1	2	3	4	5
Puffiness of eyelids	1	2	3	4	5
Excessive tearing	1	2	3	4	5
Dark circles under eyes	1	2	3	4	5
Redness	1	2	3	4	5
Burning	1	2	3	4	5

Ears

Itching	1	2	3	4	5
Frequent infections	1	2	3	4	5
Popping	1	2	3	4	5
Fullness	1	2	3	4	5
Pressure	1	2	3	4	5

Throat & Mouth

Frequent sore throats	1	2	3	4	5
Itching at the back of throat	1	2	3	4	5
Lump in throat	1	2	3	4	5
Laryngitis	1	2	3	4	5
Throat clearing	1	2	3	4	5

Chest

Cough	1	2	3	4	5
Phlegm production	1	2	3	4	5
Wheezing	1	2	3	4	5
Frequent chest colds	1	2	3	4	5
Frequent bronchitis	1	2	3	4	5

Skin

Hives	1	2	3	4	5
Rashes	1	2	3	4	5
Eczema	1	2	3	4	5
Swelling	1	2	3	4	5
Excessive perspiration	1	2	3	4	5
Itching	1	2	3	4	5
Reaction to jewelry	1	2	3	4	5
Reaction to cosmetics	1	2	3	4	5