ALLERGY PROFILE

Symptoms of Common Allergies

Patient Name:______________________________________ **Date:** ________________

PLEASE PLACE A ✓ BESIDE THE PROBLEMS YOU ARE EXPERIENCING

☐ SNEEZING	☐ WATERY EYES	☐ THROAT DRAINAGE	☐ THROAT TICKLE
☐ RUNNY NOSE	☐ SWOLLEN LIDS	☐ BLOCKED EARS	☐ WHEEZING
☐ BLOCKED NOSE	☐ ITCHY EYES	☐ ITCHY EARS	☐ TIGHTNESS IN CHEST
☐ LOSS OF SMELL	☐ SORE THROAT	☐ EAR INFECTION	☐ SHORTNESS OF BREATH
☐ HEADACHE	☐ ITCHY MOUTH	☐ COUGH	

Caused by: ____

☐ SKIN ITCH	☐ SWELLING OF LIPS	☐ NAUSEA	☐ IRRITABILITY
☐ RASH	☐ ITCHY HANDS OR FEET	☐ DIARRHEA	
☐ HIVES OF WELTS	☐ STOMACH PAINS	☐ FATIGUE	

1. When did symptoms start? ____
2. What is the worst time of the year? ☐ Spring ☐ Summer ☐ Fall ☐ Winter
3. What is the best time of the year? ☐ Spring ☐ Summer ☐ Fall ☐ Winter
4. What triggers your symptom? ☐ Weather ☐ Exertion ☐ Infection

Present Medications:____

Previous treatment: ☐ **Allergy Testing** ☐ **Allergy Shots** ☐ **Other Medications**

Are you allergic to any of the following:

☐ **Animals**	☐ **Foods**	☐ **Insects**
☐ **Dust**	☐ **Medicines**	☐ **Smoke**

What medications are you allergic to? ____________________________________

Family History:

Does anyone in your family have allergies? ☐ YES ☐ NO ☐ Unknown (If yes, check below)

☐ FATHER ☐ MOTHER ☐ BROTHER ☐ SISTER ☐ CHILDREN

Is anyone in your family a patient here? ☐ YES ☐ NO

Home Environment:

Your house is ☐ OLD ☐ NEW

Does your home have:

☐ CARPET ☐ AIR CONDITIONING ☐ PLANTS ☐ PETS ☐ SMOKER IN HOUSE

Additional Comments?