DAVID SCOTT JONES, M.D., P.C.
LESLIE P. STONE, M.D.
P. MICHAEL STONE, M.D., M.S.
MARIANA COOPER, PA-C

ALLERGY HISTORY

Instructions:
Carefully complete in full. Accuracy and thoroughness are essential. Print all answers. Relate all answers to your own experiences, not to previous advice on skin test. This form must be completed prior to seeing the physician. All information will be considered confidential.

Name _____Street _____

City _____ State _____ Zip _____ Telephone _____

Age _____ Sex _____ Race _____ Occupation _____

State problems you wish to discuss: _____

_____

When did it begin?_____ (year) How often does it occur?_____(# of times per day, week, etc.)
Worse at night or day? _____ How long does it last? _____ (hours, days, etc.)

Check months most severe:

❑ All months

❑ January	❑ April	❑ July	❑ October
❑ February	❑ May	❑ August	❑ November
❑ March	❑ June	❑ September	❑ December

What do you think makes it better? _____

_____

What do you think makes it worse? _____

_____

What do you think causes the problem? _____

_____

Check items that affect your symptoms

Irritants	❑ Cleanser	❑ Detergent	❑ Cooking odor	❑ Perfume
	❑ Powder	❑ Tobacco smoke	❑ Other smoke, specify: _____	
	❑ Moth balls	❑ Motor fumes	❑ Paint lacquer	❑ Wax
	❑ Glue	❑ Insect spray	❑ Fertilizers	❑ Ammonia
	❑ Room deodorants	❑ Chemical fumes	❑ Clorox	❑ other: _____

Toiletries
❑ Soap ❑ Shampoo ❑ Shaving cream ❑ Aftershave
❑ Spray deodorant ❑ Hair spray ❑ Hair tonic ❑ Hair dye
❑ Hand cream ❑ Make-up ❑ Toothpaste ❑ Denture cream
❑ Mouthwash ❑ Nail polish ❑ Other: _____

Foods
❑ Milk ❑ Cheese ❑ Eggs ❑ Fish
❑ Shellfish ❑ Nuts ❑ Chocolate ❑ Alcohol
❑ Wine ❑ Beer ❑ Juices ❑ Spices
❑ Vegetables ❑ Strawberries ❑ Wheat products ❑ Very cold liquids
❑ _____

Pets
Which of these do you have as pets?
❑ Dog ❑ Cat ❑ Bird ❑ Horse
❑ Hamster ❑ Rabbit ❑ Other: _____
Is your condition worse around pets? ❑ Yes ❑ No
Specify: _____

Drugs
❑ Penicillin ❑ Sulfa ❑ Over-the-counter drugs, specify: _____
❑ Other: _____

Weather
❑ Hot ❑ Cold ❑ Humid ❑ Damp
❑ Pollution ❑ Smog ❑ Sunlight ❑ Air-conditioning
❑ Change in temperature

New clothing (unwashed)
❑ Wool ❑ Silk ❑ Sweater ❑ Coat
❑ Shoes ❑ Dry-cleaned clothes ❑ Starched clothes ❑ Other: _____

Contactants
❑ Poison ivy ❑ Cut grass ❑ Cut flowers ❑ Household plants
❑ Hay ❑ Christmas trees ❑ Plastic ❑ Rubber
❑ Fiberglass ❑ Dust ❑ Wool blankets ❑ Feather pillows
❑ Mattress ❑ Furs ❑ Rugs ❑ Overstuffed Furniture
❑ Other: _____

Check symptoms experienced

General
❑ Nervousness ❑ Dizziness ❑ Fainting ❑ Sinus trouble
❑ Frequent colds ❑ Fatigue ❑ Other: _____

Headache
❑ Where? (front, back, right, left) _____ ❑ Day ❑ Night
❑ Aching ❑ Throbbing ❑ Sharp ❑ Dull
❑ With vomiting ❑ Stuffy nose ❑ Better with sleep ❑ Worse with tension
❑ Spots before eyes.
Cause:
❑ Migraine ❑ Food ❑ Sinus ❑ Tension
❑ Drug ❑ Other: _____

Skin
❑ Rash ❑ Hives ❑ Eczema ❑ Blisters
❑ Itching ❑ Swelling ❑ Burning ❑ Stinging
❑ Redness ❑ Perspiration ❑ Dandruff ❑ Athlete's foot
Where:_____ worse after eating? ❑ Yes ❑ No

Eyes
❑ Tearing ❑ Burning ❑ Itching ❑ Pain
❑ Redness ❑ Discharge ❑ Puffiness ❑ Infections
❑ Blurring of vision ❑ Glaucoma ❑ Other: _____

Ears
❑ Pressure ❑ Itchiness ❑ Drainage ❑ Bleeding
❑ Infections ❑ Deafness ❑ Swelling ❑ Other: _____

Nose
❑ Sneezing ❑ Stuffiness ❑ Sniffles ❑ Clear running discharge
❑ Itching ❑ Cloudy discharge ❑ Difficult in smelling ❑ Snoring
❑ Polyps ❑ Postnasal drip ❑ Bleeding ❑ Broken nose
❑ Previous surgery ❑ Other:_____

Tongue
❑ Swollen ❑ Sore ❑ Itching ❑ Coated
❑ Difficulty in tasting ❑ Other: _____

Mouth
❑ Itching of roof ❑ Repeated tonsillitis ❑ Tonsils removed ❑ Morning sore throats
❑ Bad breath ❑ Swollen lip ❑ Trouble swallowing ❑ Frequent throat clearing
❑ Mouth breathing ❑ Change in voice ❑ Other: _____

Mucus
❑ Thick ❑ Thin ❑ Clear ❑ Yellow
❑ Green ❑ Brown ❑ Bloody
Amount per day (teaspoon, tablespoon, ½ cup)_____
Source of mucus (nose, lungs, throat)_____

Chest
❑ Shortness of breath ❑ Wheeze ❑ Pain ❑ Tightness
❑ Cough ❑ Cough with wheeze ❑ Difficulty in walking ❑ Difficulty in working
❑ Difficulty in sleep ❑ Heart trouble ❑ High blood pressure ❑ Emphysema
❑ Bronchitis ❑ Pneumonia ❑ Tuberculosis ❑ Cancer
❑ Other: _____

Stomach
❑ Vomiting ❑ Gas ❑ Cramps ❑ Belching
❑ Diarrhea ❑ Mucus in stool ❑ Blood in stool ❑ Foul-smelling stool
❑ Soiling: Worse after eating what foods?_____
Other: _____

Joints
❑ Pain ❑ Stiffness ❑ Swelling ❑ Other: _____

Menses
❑ Regular ❑ Irregular ❑ Discharge ❑ Itching
❑ Cramps ❑ Infections ❑ Last period (date) _____Pain: ❑ Yes ❑ No
Are you pregnant now ❑ Yes ❑ No Taking birth control pills: ❑ Yes ❑ No

Kidneys
❑ Pain ❑ Frequent urination ❑ Bladder infection ❑ Recurrent infection
❑ Itching ❑ Chills ❑ Fever ❑ Other: _____

Check permanent items and fill in the blanks

Where do you live?
❑ Room ❑ Apartment ❑ Brick house ❑ Wood-frame house
❑ Mobile home Age of house _____

Location
❑ City ❑ Suburb ❑ Country ❑ Farm
❑ Seashore ❑ Desert ❑ Mountains ❑ Near factory
❑ Near bakery ❑ Near grain storage ❑ Near swamp ❑ Near poultry yard
❑ Near barn ❑ Other:
_____

Problem worse in
❑ Bedroom ❑ Living room ❑ Kitchen ❑ Basement
❑ Attic ❑ Garage ❑ Indoors ❑ Outdoors
❑ Other:_____

Type of heating
❑ Forced air ❑ Radiator ❑ Electric ❑ Heat pump
❑ Filtered air ❑ Other:_____

Problem worse when
❑ At home ❑ At work ❑ In car ❑ In boat
❑ Exercising ❑ Hair salon ❑ At school ❑ Driving in traffic
❑ Sweeping ❑ House cleaning ❑ Making beds ❑ Around open windows
❑ Around humidifier ❑ Around vaporizer ❑ Around fans ❑ Around heating ducts
❑ On windy day ❑ Swimming in chlorinated water ❑ Taking hot or cold baths
❑ In most places ❑ Other:
_____

Insect bites or stings
❑ Large swelling ❑Weakness ❑ Sweating ❑ Short of breath
❑ Stuffy nose ❑ Wheezing ❑ Other: _____

Smoking habits
❑ Cigarettes ❑ Cigars ❑ Pipe
Number per day:_____ How long? (Years)_____

Medications (please include dosage) _____

now used _____

_____

Place age of family member having any of the following conditions in the appropriate space:

	Father	Mother	Brothers	Sisters	Children	Other
Migraine						
Hives						

Emphysema						
Asthma						
Cystic Fibrosis						
Eczema						
Hay Fever						
Tuberculosis						
Thyroid Disease						
Glaucoma						

Unusual activities engaged in just prior to onset of symptoms:

_____

_____

_____

_____

Unusual food or drink ingested just prior to onset of symptoms

_____

_____

_____

_____

RECOMMENDATIONS

_____

_____

_____

_____

_____