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UNIVERSITY OF MISSISSIPPI MEDICAL CENTER
DIVISION OF ALLERGY AND IMMUNOLOGY

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MEDICAL HISTORY AND ALLERGY SURVEY

Please complete this form. It is important for your doctor to know the details about your medical history and allergy symptoms. If needed, you may use the back of each page to complete your answers.

NAME_____ **AGE**_____ **DATE**_____

WHO REFERRED YOU TO SEE US?_____

Circle the allergy problems that you have:

(1) Hay fever/Sinus
(2) Asthma/Bronchitis
(3) Hives/Swelling
(4) Eczema
(5) Drug allergy
(6) Food allergy
(7) Insect allergy
(8) Cough
(9) Headache
(10) Immune system
(11) Other:_____
_____

I. CLINICAL HISTORY

A. Describe your major allergy symptoms. How do they make you feel?

_____
_____
_____

B. What are your expectations from this allergy consultation?

_____
_____

II. SYMPTOMS (check)

Eyes: Itching___ Swelling___ Burning___ Tearing___ Discharge___

Ears: Itching___ Fullness___ Popping___ Decreased hearing___ Pain___

Nose: Sneezing___ Itching___ Runny nose___ Mouth breathing___ Decreased Smell/Taste___

Nasal obstruction___ Discolored discharge___

Facial Pressure___ Headache___ Where?_____

Throat: Itching___ Soreness___ Post-nasal drip___ Throat clearing___ Swelling___

Chest: Cough___ Sputum___ Color and amount_____

Wheezing___ Chest tightness___ Shortness of breath with exercise___

Skin: Rash___ Eczema___ Hives___ Swelling___

Where on your body?_____

A. Age at onset of your allergies:_____

B. Are you having more allergy problems recently?_____

C. Do you have daily symptoms?_____

D. What time of day or night is the worst time for you?_____

E. Do you have seasonal symptoms?_____

F. What time of the year are your allergies worse? (Please list months)_____

G. Please list any particular exposure (such as cat, dust, smoke, freshly cut grass) that makes you much worse.
_____

H. Please list all **food** allergies. (List the food, type of reaction, and approximate date of reaction)
_____

I. Please list all **drug** allergies. (List the name of drug, type of reaction, and approximate date of reaction)
_____

J. Have you had a life-threatening allergic reaction to a **stinging insect** (bee, wasp, yellow jacket, hornet, fire ant)?
_____

K. Have you had **hives** previously?_____

L. Have you had **eczema** previously?_____

III. PREVIOUS ALLERGY EVALUATION AND TREATMENT

A. Name of allergist and city:_____

B. Please list your allergies:_____

C. Have you received allergy shots?_____
Were allergy shots beneficial?_____
When did you start and how long were you on allergy shots?_____

D. What have you done to reduce allergies in your home?_____

E. Please circle which medicines you have tried to treat your allergies/asthma:

Medicines for Allergies

Pills:	Allegra, Claritin (Loratadine), Clarinex, Periactin, Vistaril (Hydroxyzine), Xyzal, Zyrtec (Cetirizine) Benadryl, Chror-Trimeton, Dimetapp Allergy, Tavist, Tylenol Allergy Singulair Other:_____ Improved___ Not improved___ Sedation___
Eye Drops:	Elestat, Optivar, Pataday, Patanol Alamast, Alocril, Alomide, Crolom Clear Eyes, Naphcon-A, Visine Allergy, Zaditor, Zyrtec Other:_____ Improved___ Not improved___
Nose Sprays:	Flonase (Fluticasone), Nasacort, Nasalide (Flunisolide), Nasarel, Nasonex, Omnaris, Rhinocort, Veramyst Astelin, Astepro, Patanase Afrin, Mucinex Nasal Spray, Vicks Sinex, Nasalcrom Other:_____

Improved___ Not improved___ Side Effects_____

Medicines for Asthma

Pills: Accolate, Singulair, Zyflo
Theophylline (Theo-Dur, Slo-Bid, Uniphyl, Unidur)
Steroids (Prednisolone, Prednisone, Medrol)
Other:_____
Improved___ Not improved___ Side Effects_____

Inhaled: **Quick-Acting**: Albuterol, Alupent, Breathaire, Maxair, Primatene Mist, ProAir, Proventil, Tomolate, Ventolin, Xopenex
How often do you use?_____
Long-Acting: Foradil, Serevent
Steroid: Aerobid, Alvesco, Asmanex, Azmacort, Flovent, Pulmicort, QVAR
Combination: Advair Diskus, Advair HFA, Symbicort
Other: Intal, Tilade
Other:_____
Improved___ Not improved___ Side Effects_____

Injected: Xolair
Other:_____
Improved___ Not improved___ Side Effects_____

Antibiotics for respiratory infections (sinusitis, bronchitis, pneumonia):
Name:_____
How often do you use?_____
Improved___ Not improved___ Side effects (rash, swelling, etc.) _____

Other Treatment/Medications: Please list all your prescribed and over-the-counter medications (include aspirin, laxatives, sleeping medications, and herbal supplements). _____
_____

IV. PAST MEDICAL HISTORY

A. Please list all important operations and other significant hospitalizations that you have had, even if they are unrelated to your allergy/asthma problem. _____
_____

B. Have you been hospitalized for asthma? _____
When?_____ Where?_____

C. Do you have, or have you had, any other medical problems?
Diabetes___ Thyroid disorder___ High blood pressure___ Seizures___ Glaucoma___ Kidney___
Arthritis___ Hepatitis___ Ulcers___ Other_____

D. Have you experienced recurrent sore throats, repeated sinus infections, or severe infections, such as pneumonia or meningitis?_____

E. Have you had nasal polyps, adverse reaction to aspirin, or sinus surgery?_____

F. Have you had an adverse reaction to latex products (rubber gloves, balloons, condoms, catheters) such as hives, blisters, swelling, itching eyes, sneezing, throat-clearing, or coughing?_____

G. Have you had a chest x-ray or CT scan, sinus x-ray or CT scan, lung function tests, EKG, or blood tests? Please comment on the results._____

H. Are your vaccinations up to date?_____
Do you receive the Flu vaccine yearly?_____

Have you received the Pneumovax (for pneumonia)?_____

V. ENVIRONMENTAL HISTORY

A. Do your symptoms occur around any specific environment, exposure, location, or activity (lawn mowing, animals, dusty environments, old leaves, strong odors, exercise)? _____
_____

B. Do you suspect that anything in your home, work place, or other locations causes your symptoms? Describe:_____

C. What type of home do you have (house, mobile home, condo) and what is the surrounding area like (suburbs, country)? _____

D. Do you have indoor animals? Or outdoor animals? Please list._____

E. Do you have a feather, foam, or polyester fiber pillow?_____

F. How old is your mattress? _____ Or waterbed?_____

G. Do you have carpeting in your home?_____ Where?_____

H. Are your windows opened or closed most of the time?_____

I. Do you have central air conditioning?_____

J. Does air conditioning help your symptoms?_____

K. Do you use a humidifier?_____ Air purifier?_____ Ceiling fans?_____ Fire place?_____

L. Do your symptoms become better or worse on vacations, trips, or at the beach? _____

M. Do you have symptoms after eating at home or in a restaurant? _____

N. Does a change in the weather influence your allergic symptoms?_____

O. Do strong odors, perfumes, powders, fumes, cigarette smoke make you worse?_____

VI. PERSONAL AND SOCIAL HISTORY

A. Do you presently smoke (how much and for how long)?_____

B. Have you ever smoked (how much and for how long; when did you quit)?_____

C. How much alcohol do you drink?_____

D. Do you use recreational drugs? (<u>This is confidential.</u>)_____

E. What is your occupation?_____

F. Are you exposed to any toxic chemicals, noxious substances, or cigarette smoke?_____

G. How long have you lived in Jackson and/or Mississippi?_____

H. Where have you lived previously?_____

I. Are you happy with your life? If not, why?_____

J. How many other people live in your home?_____

K. Do any of them smoke?_____

VII. FAMILY HISTORY

A. Are there any members of the immediate family who have asthma, hay fever, eczema, hives, food allergies, drug allergies, insect allergies, and recurring and/or frequent infections? Please list and comment.
Mother:_____
Father:_____
Brother/Sister:_____
Son/Daughter:_____

B. Are there any hereditary diseases or other disorders that seem to occur frequently in your family (arthritis, diabetes, emphysema, heart problems)?_____

VII. REVIEW OF SYSTEMS

Do you have any of the following? (Check)

General
_____weight loss
_____chills
_____fevers
_____loss of appetite
_____dry mouth

Eyes and Ears
_____dry eyes
_____change in vision
_____trouble hearing
_____ringing in ears

Skin
_____skin rashes
_____recurrent skin infections

Gastrointestinal
_____nausea
_____vomiting
_____diarrhea
_____change in bowel habits
_____trouble swallowing
_____heartburn

Cardiovascular
_____chest pain
_____chest pain with exercise
_____calf pain with exercise
_____ankle swelling

Kidney
_____trouble starting urine
_____bed wetting
_____burning with urination
_____loss of urine with cough/sneeze
_____frequent urination during the night

Blood
_____had anemia
_____bleed or bruise easily
_____swollen lymph nodes

Musculoskeletal
_____morning joint stiffness and aching
_____painful, swollen joints
_____muscle tenderness or pain
_____muscle weakness

Endocrine
_____cold intolerance
_____heat intolerance
_____increased thirst
_____frequent urination

Gynecological
_____excess bleeding
_____vaginal discharge
_____change in menstrual cycle

Neurological
_____weakness/clumsiness
_____tingling, burning, or numbness of hands or feet

Psychological
_____fearful, anxious
_____excessive worry
_____crying spells
_____trouble sleeping
_____behavior problems
_____anxiety or depression

Other
_____lumps or bumps under arms, breasts
_____skin rashes in the groin
_____skin rashes on the toes
_____skin rashes on the feet