SHER ALLERGY SPECIALISTS

A Division of Florida Pediatrics Association, LLC
11200 Seminole Blvd., Suite 310, Largo FL 33778

Patient's name: _____ **Date of Birth:** _____

INSTRUCTIONS: Please answer the questions as they relate to the person being evaluated. A complete, accurate record is important in learning about your allergy problem.

1. Briefly, describe the reason for your allergy visit and what you hope to accomplish:

_____

_____

2. PROBLEMS: Have you ever had the following problems or conditions:

Yes	Check all items that apply	Age at onset	Severity Mild, Moderate or Severe
	Asthma		
	Any other breathing problems		
	Sinus trouble		
	Hay Fever (Nasal Allergies)		
	Hives or swelling		
	Eczema or other rashes		
	Frequent infections		
	Insect reactions		
	Latex allergy		
	Metal allergy		

3. SYMPTOMS: Are you having any of the following? Circle all that apply and INDICATE FREQUENCY.

NASAL & SINUS	HOW FREQUENT	SINUS	HOW FREQUENT	CHEST	HOW FREQUENT	INFECTIONS	HOW FREQUENT
Runny Nose (one side or both)		Mouth breathing/snoring		Cough with exercise		Ear infections	
Stuffy Nose (one side or both)		Decreased sense of smell		Cough with laughter		Throat infections	
Discolored nasal drainage		Loss of smell		Cough – middle of night		Sinus infections	
Post nasal drip		Sleep Apnea		Cough – laying down		Pneumonia	
Itchy nose		Sinus pain		Cough – upon awakening		Bronchitis	
Sneezing		Sinus x-rays		Wheezing		Other infections	
Throat clearing		Head or sinus CT scan		Shortness of breath		**HEADACHES**	
Cough		**EYES**		Chest Tightness		Frequent headaches	
Hoarseness		Itching		**SKIN**		Severity?	
Bad breath		Redness		Rash		Triggers?	
Sore throat		Watery		Swelling		Pressure	
Nose bleeds		Dark circles		Itching		Unilateral	
Nasal Polyps		Dry Eyes		Bruising		Bilateral	
		GASTROINTESTINAL		Dry Skin		Visual Distributions	
		Heartburn		Eczema		Nausea	
		Acid Reflux		Hives		Vomiting	

Are symptoms present year round?

_____

Is there a time of year that symptoms are worse?

_____

4. PRECIPITATING FACTORS/TRIGGERS: For each item below, check the appropriate square to indicate whether Symptoms or condition is affected by the following precipitants/trigger.

CONDITION IS MADE:	WORSE	IMPROVED	NO CHANGE	CONDTION IS MADE:	WORSE	IMPROVED	NO CHANGE
Cutting or playing in the grass or raking leaves				Paint lacquer, glue, mothballs, motor fumes, chemicals, fertilizers, insect spray, cooking odors, etc. Specify:			
High winds, riding in auto				Trips away from home			
Other outdoor exposure				Other strong odors Specify:			
Mold or mildewed areas				Exposure to animals Specify:			
Sweeping, dusting, or vacuuming				"colds" or viruses			
Smog, smoking or smoke exposure				Physical exertion or exercise			
Air conditioning or heating				Cold weather			
Cleaning agents, detergents, ammonia, bleach, soap, conditioner, shaving cream, toothpastes, etc. Specify:				Other factors:			

5. FOOD REACTIONS: Have you ever had any symptoms (rash, hay fever, vomiting, gas, cramps, diarrhea, or colic as an infant) after the ingestion of any food, liquid, MSG, Sulfites, or food coloring? If yes, please give details below.

FOOD	DATE	SYMPTOMS	CAN FOOD BE EATEN? YES	NO	DATE FOOD WAS LAST EATEN

6. PREVIOUS ALLERGY EVALUATION AND THERAPY

Have you ever had allergy skin tests? ○ Yes ○ No If yes, date (how long ago) _____ Physician's name _____

What were the results of these tests: _____

Have you ever received allergy shots? ○ Yes ○ No If yes, give dates: _____

Did your symptoms improve while you received shots? ○ Yes ○ No

Did you ever experience an adverse reaction to an allergy injections? ○ Yes ○ No

If yes, please specify: _____

Do you or have you ever used over the counter nasal sprays? ○ Yes ○ No

If yes, please specify: _____

List all medication(s) you have taken for allergies in the past:

1. _____ 4. _____

2. _____ 5. _____

3. _____ 6. _____

7. DRUG/MEDICATION/IMMUNIZATION ALLERIES & INTOLERANCES:

List all drug allergies and the reactions (hives, rash, nausea, vomiting, diarrhea, difficulty breathing, etc.

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

8. MEDICATIONS (INCLUDING OVER-THE-COUNTER):

MEDICATION NAME	STRENGTH	DAILY FREQUENCY	MEDICATION NAME	STRENGTH	DAILY FREQUENCY
1.			6.		
2.			7.		
3.			8.		
4.			9.		
5.			10.		

9. MEDICAL HISTORY (HAVE YOU EVER BEEN DIAGNOSED WITH) CHECK ALL THAT APPLY

◯ Anemia	◯ Diabetes Type 1 or Type 2:	◯ Irritable bowel syndrome	◯ Osteopenia/Osteoporosis
◯ Anxiety	◯ Fibromyalgia	◯ Jaundice/liver disease	◯ Pneumonia/Lung disease
◯ Arthritis Osteo or Rheumatoid	◯ Glaucoma	◯ Kidney disease	◯ Prostate problems
◯ Atrial fibrillation	◯ GERD/heartburn	◯ Low back pain	◯ Seizures/Epilepsy
◯ Bleeding Disorder	◯ Heart attack	◯ Migraines/Headache	◯ Sleep Apnea
◯ Cancer What kind?	◯ Heart disease	◯ Menopause	◯ Sleep disturbances
◯ Cataracts	◯ Heart failure	◯ Menstrual irregularities	◯ Thyroid disease
◯ Colon Polyps	◯ High blood pressure	◯ Neuropathy	◯ Ulcers
◯ Depression	◯ High cholesterol	◯ Obesity	◯ Urinary incontinence

Other:

10. HEALTH MAINTENANCE (LIST IF/WHEN LAST PERFORMED):

Bone density test:	MMR vaccine:
Colonoscopy:	Pneumonia vaccine:
Endoscopy:	Shingles vaccine:
Flu vaccine:	Tetanus vaccine:
COVID vaccine:	Meningococcal vaccine:

11. SURGICAL HISTORY (List any surgeries or procedures you have had performed)

Procedure	Date	Procedure	Date
1.		4.	
2.		5.	
3.		6.	

12. HOSPITALIZATIONS (List ANY hospitalizations):

WHY?	Date	WHY?	Date
1.		4.	
2.		5.	
3.		6.	

13. FAMILY HISTORY: Please indication if your blood relative (s) have had/currently have the following:

Family Member	Alive	Deceased	Year of birth/age	Asthma	Allergic Rhinitis/Hay Fever	Food Allergy	Drug Allergy	Diabetes	Hypertension/High blood pressure	Heart Disease	Mental Illness	Unknown
Mother												
Father												
Son(s)												
Daughter(s)												
Sibling(s)												

14. REVIEW OF SYSTEMS CHECK ALL THAT APPLY

○ Fatigue	○ Diarrhea	○ Weakness	○ Irregular heartbeat
○ Fever	○ Vomiting	○ Fainting	○ Abdominal pain
○ Disordered Sleep	○ Bruising	○ Anxiety	○ Joint pain
○ Weight Changes	○ Bleeding	○ Depression	○ Constipation
○ Muscle pain	○ Urinary urgency	○ Urine frequency	

15. BIRTH HISTORY: PLEASE COMPLETE THE FOLLOWING FOR DEPENDENT CHILDREN UNDER 18 YEARS OF AGE.

Place of birth: _____ Age of mother at birth: _____

Was pregnancy normal? _____ If no, please specify reason: _____

_____

Was delivered by: C-Section -or- Vaginal Patient was: Formula fed -or- Breastfed

16. MARITAL STATUS: ○ Married ○ Single ○ Widowed ○ Separated ○ Divorced

Number of Children: _____

17. RESIDENCE: LIST YOUR PAST RESIDENCES WITH YOUR MOST RECENT FIRST. LIST ONLY CITY AND STATE.

City & State	How long?	Symptoms better?	Symptoms worse?	No change

18. WORK ENVIRONMENT:

What type of work do you do? _____ Where are you employed? _____

Is your work environment: ○ Carpeted? ○ Tiled?

Are you exposed to chemicals or strong odors or anything that might aggravate your condition? _____

If yes, please specify: _____

19. SCHOOL ENVIRONMENT:

What school do you attend? _____

What grade? _____

Have you missed school because of your allergies? _____ How many days in last year? _____

Do you feel extra-curricular activities have been affected by your condition? _____

20. ENVIRONMENTAL SURVEY:	
Approximate age of house:	How old is your Pillow? _____ Mattress? _____
Are any rooms damp or musty?	Is your pillow: ○ feather ○ foam rubber ○ Dacron ○ encased in plastic ○ other: _____
Type of heating? (Electric, gas, central, etc.?)	Is your mattress: ○ innerspring ○ foam rubber ○ waterbed ○ encased in plastic ○ other: _____
Do you have: ○ air cleaner ○ Air dehumidifier	Are your sheets washed in: ○ cold ○ warm ○ hot
How often do you change/clean your air conditioner and air cleaner filters?	Do you have any: ○ Stuffed furniture ○ Feather comforters ○ Stuffed animals
Is the home: ○ carpeted ○ tiled	Do you have any pets? (List number and kind)
Is the bedroom: ○ carpeted ○ tiled	Other:

21. SOCIAL HISTORY:

Have you ever smoked? ○ Yes ○ No If yes, how many years? _____
Do you presently smoke? ○ Yes ○ No If no, when did you stop? _____
Average cigarettes per day at highest point? _____
If you still smoke, do you think you could stop? _____
Do you or family members smoke: In the house? _____ In the car? _____
Which other family members now smoke? _____

Do you drink alcohol? ○ Yes ○ No If yes, list type _____
Average weekly consumption? _____

Do you consume caffeine? ○ Yes ○ No If yes, how many caffeine drinks do you consume in a day? _____

Do you use drugs other than for medical reasons? ○ Yes ○ No If yes, list type _____