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Board Certified  
 Children & Adults  
 www.ohioallergy.com

**Today's Date:** \_\_\_\_\_

**PATIENT NAME:** \_\_\_\_\_ **D.O.B.** \_\_\_\_\_

<b>Previous Allergy Evaluation:</b> Yes No		<b>Environmental History:</b> (please circle)	
Date		Home	Apartment Home City Country Farm
Place		Flooring	Carpet Tile Wood
By Whom		Air Conditioning?	Yes No
Results		Heating	Electric Gas Wood Other
		Pillow	Foam Feather/Down Fiberfill Other
		Stuffed Animals?	
		Mattress	Box Springs Waterbed
		Houseplants?	Yes No
		Exposed to animals?	Cat Dog Other _____
		Irritants that make your symptoms worse: _____	
Allergic to any foods?: Yes No if so please list _____			
Drug Allergies?: Yes No if so please list _____			
Any problems with insect stings?: Yes No			
Any history of?: Hives Poison Ivy Bronchial Asthma			
Any medical problems?: Diabetes Reflux Hypertension Heart murmurs			
Other (list) _____			
Any related surgery?: Sinus Ear Tubes Tonsils Adenoids			
<b>Family History:</b>			
Asthma Bronchitis Hay Fever Eczema Migrane Hives Drug Allergy			
Asprin Allergy Nasal Polyps Sinus Problems Cystic Fibrosis/Emphysema Immunodeficiency			
<b>Occupational and Social History:</b>			
Smoking history? Yes No If yes, packs per day? _____ For how many years? _____			
Alcohol history? Daily Occasional Never Number of drinks _____ per Day Week Month			

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