

Crawford & Fitch - Ear, Nose and Throat

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ALLERGY HISTORY FORM

Date: _____

Patient's Name: _____
Last
First
Initial
Sex:
Age:

Street: _____ City: _____ State: _____ Zip: _____

Home Telephone No: _____ Business Telephone No: _____
Area Code
Number
Area Code
Number

To be filled out by patient Your answers to the following questions will help to determine the cause of your allergy symptoms. It is important to check (✓) each question as accurately as possible.

Describe what symptoms bother you most.

 When did these symptoms begin?

During what months do you usually have symptoms?

All Months	_____
January	_____
February	_____
March	_____
April	_____
May	_____
June	_____
July	_____
August	_____
September	_____
October	_____
November	_____
December	_____

List any allergy medications that work well for you:

List any medication taken on a regular basis:

Do any of your blood relations have allergies?

Have you ever had skin or blood tests for allergies before now?
 When? _____
 Treatment? _____
 How Long? _____

	Yes	No
Have trouble with your skin?		
Eczema		
Hives		
Other		

Have trouble with your ears?		
Popping/Fullness		
Itching		
Hearing loss		
Fluid in ears		
Infection/Pain		
Dizzy		

Have trouble with your throat?		
Frequently sore		
Itching throat/Mouth		
Frequent throat clearing		

Have trouble with your eyes?		
Redness		
Itching		
Tearing		
Puffiness		
Dark Circles		

Have trouble with your nose?		
Clear/colorless drainage		
Thick/colored drainage		
Nasal Itching/rubbing		
Constant stuffiness		
Periodic stuffiness		
Sinuses		
Sneezing		
Mouth breathing or snoring		
Post nasal drip		

	Yes	No
Have trouble with your chest?		
Wheezing with colds/dust/pollen/animal		
Wheeze/Cough after exercise?		
Cough?		
What kind?		
Deep/productive		
Constant		
Dry/tight		
Eyes had bronchitis or pneumonia?		
When _____		

Do you get headaches?		
Moderate		
Severe		
Present most of the time		
Present part of the time		
Interfering with your life or job		

Have trouble with your digestive system?		
Bad breath		
Retasting/Heartburn		
Nausea		
Vomiting		
Bloating		
Diarrhea		
Constipated		
Rectal Itch		
Excess Gas		
Indigestion		

List any foods or beverages that you crave or eat frequently

Food(s) _____



List any foods which you suspect cause symptoms:

Food _____	Symptom _____
Food _____	Symptom _____
Food _____	Symptom _____
Food _____	Symptom _____
_____	_____
_____	_____

	Yes	No
Do you drink alcohol? # of times/week _____		
Do you drink milk as a beverage? # of times/day _____		
Do you eat milk products such as yogurt, cheese, ice cream? # of times/week _____		

Do you experience unusual fatigue?		
Ladies, do you experience an increase in symptoms related to your menstrual cycle?		
Do you have joint/muscle pain on a frequent basis?		
Do you get sick frequently?		
Do you have fungal problems? (skin, athlete's foot, vaginitis, prostatitis)		

Which of the following do you think cause your symptoms or make them worse?	Yes	No
Indoors		
Outdoors		
Home		
Morning		
Afternoon		
Night		
Weather change		
Wet weather		
Windy day		
Hot day		
Cold day		
Air conditioning		
In barns, hay		
Damp areas		
Mowing lawn		
Dusty environment		
High air pollution		
Animals		
Smoke		
Perfumes		
Other _____		

	Yes	No
Have you ever reacted to any medication?		
List:	_____	



Do you live in: (circle)		
House/trailer or		
Apartment		
In the city		
In the country		
In your dwelling New?		
Older than 25 years?		
Do you have a wet or damp basement?		
Do you live near water?		
Describe _____	_____	
Do you have carpet in your bedroom?		
How old is it? _____	_____	
Lots of house plants?		
Does your pillow/comforter contain feathers?		
How old is your mattress?		

Do you use a humidifier/vaporizer frequently?		
Do you use air conditioning?		
At work		
At home		
In the bedroom		

Is your heating system:		
Gas		
Wood		
Electric		
Oil		
Do you use space heaters? (describe) _____	_____	

Is there anything else about your problem that you think may be important or unusual?

	Yes	No
Do you have animals in your home?		
List:	_____	



Smokers in your home?		
Do you smoke?		
Cigarettes # _____ /day	_____	
Years smoked? _____	_____	
Stopped smoking in 19 _____	_____	



Describe your occupation:

Are any materials used in your occupation or hobbies that you think have something to do with your condition?

(describe):

At Work are your symptoms		
Better?		
Worse		
The same		

