UT HEALTH THE UNIVERSITY OF TOLEDO

History Allergy

Patient Label

What is your chief complaint or most bothersome symptom(s)?_____

_____

What medications have you taken in the past 5 days?_____

_____

Hospital stays? ☐ Yes ☐ No If so for what?_____

Have you ever been diagnosed with any of the following: Check those that apply to you below.

☐ Hay fever ☐ Asthma ☐ Pneumonia ☐ Bronchitis ☐ Hives (welts) ☐ Eczema ☐ Insect Allergy

☐ Other:_____

Have you ever been on allergy injections? ☐ Yes ☐ No If yes, When?_____ How long?_____

Did they help? ☐ Yes ☐ No Who provided the vaccine?_____

Have you had a positive skin test to: ☐ Dust mites ☐ Trees ☐ Grasses ☐ Weeds ☐ Molds ☐ Cats ☐ Dogs ☐ Foods ☐ Feathers ☐ Other:_____

Check those that apply:

Nose:	☐ Itchy	☐ Blocked	☐ Runny	☐ Bleeding	☐ Sneezing
Eyes:	☐ Itchy	☐ Watery	☐ Swollen	☐ Burning	☐ Red
Ears:	☐ Itchy	☐ Blocked	☐ Ringing	☐ Pain/Ache	☐ Hearing
Sinuses:	☐ Stuffy	☐ Headache	☐ Infections		
Chest:	☐ Cough	☐ Wheezing	☐ Post nasal/Throat clearing	☐ Tightness	☐ Cough with exercise
Skin:	☐ Itchy	☐ Dry	☐ Hives	☐ Eczema	☐ Rashes
Other:	☐ Loss of smell	☐ Nasal polyps	☐ Itchy mouth	☐ Itchy throat	☐ Infections

Please list all current Medications:

_____

_____

When are your symptoms worst:

☐ Spring ☐ Summer ☐ Fall ☐ Year-round ☐ Winter ☐ At home ☐ At work ☐ Both

Does exposure to any of the following aggravate your symptoms? ☐ Dust ☐ Mold ☐ Leaves ☐ Cold air ☐ Smoke ☐ Storms ☐ Cats ☐ Dogs ☐ Rain ☐ Feathers ☐ Exercise ☐ Cut grass ☐ Other:_____

When visiting or living in other areas, are your symptoms: ☐ Better ☐ Same ☐ Worst ☐ Unknown

Medicines that helped you?_____

Medicines that did not help you?_____

Hospitalizations for Chest Symptoms:

Have you ever been hospitalized overnight for asthma or any other lung problems? ☐ Yes ☐ No

If so, what problem and when?_____

In the last 12 months have you needed any urgent physician or emergency room care? ☐ Yes ☐ No

How many visits?_____ How many days of work/school were missed per year?_____

Any Reaction to Foods, Medications or Insects: (check all that apply)

☐ Peanuts ☐ Soy ☐ Tree Nuts ☐ Milk ☐ Eggs ☐ Wheat ☐ Fish ☐ Shellfish ☐ Seeds
☐ Fruits ☐ Vegetables ☐ Spices ☐ Penicillin ☐ Aspirin ☐ Local Anesthetic ☐ Bees
☐ Yellow Jackets ☐ Wasps ☐ Hornets ☐ Mosquitoes ☐ Ants

Other:_____

Symptoms: ☐ Local reaction ☐ Itchy mouth or lips ☐ Hives ☐ Wheezing

Explain:_____

H P S C A N

UT HEALTH THE UNIVERSITY OF TOLEDO

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What are your hobbies?_____

_____

Occupation:_____Chemical exposure at work or at home: ☐ Yes ☐ No

_____

Do you get rashes from contact with:

☐ Poison Ivy ☐ Grass ☐ Latex/rubber ☐ Mango ☐ Plastic ☐ Nickel/Metal ☐ Adhesive ☐ Cosmetics

☐ Leather ☐ Describe:_____

Patient less than 15 years old:

Delivery: ☐ Normal ☐ Other:_____

Neonatal problems (example: premature birth)?_____

Feeding problems:_____

Immunizations – Any unusual problems?_____

What illnesses do you have or have you had?

☐ Pneumonia___times ☐ Rheumatic Fever ☐ Emphysema ☐ Diabetes ☐ Tuberculosis ☐ Heart Disease

☐ Heart Murmur ☐ Glaucoma ☐ High Blood Pressure ☐ Ulcer ☐ Unusual Infections

☐ Arthritis ☐ Thyroid Disease ☐ Liver Disease ☐ Kidney Disease ☐ Prostate Cancer

☐ Other:_____

Family History: (check one) ☐ Married ☐ Single ☐ Divorced

Are your parents alive: Mother: ☐ Yes ☐ No Father: ☐ Yes ☐ No

If parents died, at what age: Mother: _____ Father: _____

Do you have brothers: ☐ Yes ☐ No Sisters: ☐ Yes ☐ No

Do you have children: Sons:_____ Daughters:_____

Are there any unusual medical problems in the family? If so, explain: ☐ Yes ☐ No _____

_____

_____

_____

	Hay Fever	Asthma	Eczema	Hives	Insect Allergy	Drug Allergy	Sinus	Food	Other
Mother									
Father									
Sisters									
Brothers									
Aunts									
Uncles									
Grandmothers									
Grandfathers									
Others									

Where did you grow up?_____

How long have you lived in this area?_____

If less than 5 years, where did you live in the previous 5 years?_____

_____

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History Allergy

Patient Label

Residence (check all that apply)

☐ Urban ☐ Rural ☐ House ☐ Townhouse ☐ Condominium ☐ Mobile Home ☐ Apartment Age_____

Basement: ☐ Dry ☐ Damp ☐ Frequent Mildew

☐ Water damage in house: ☐ Yes ☐ No

Heated and Cooled by (check all that apply)

☐ Forced Air ☐ Gas ☐ Electric ☐ Radiators ☐ Baseboard ☐ Hot Water

☐ Heat Pump ☐ Central Air Conditioning ☐ Attic Fan ☐ Window Air Conditioning

☐ Window Fan ☐ Other:_____

☐ Humidifier ☐ De-Humidifier ☐ Room Hepa or Air filter

Smokers in Home: ☐ Yes ☐ No

Pets: ☐ Cat(s) ☐ Dog(s) In bedroom? ☐ Yes ☐ No

Indoor Plants: ☐ Many ☐ Few ☐ In bedroom

Unusual or foreign items in house? (ex: silk):_____

Bedroom:

Bedroom items: ☐ Stuffed furniture ☐ Heavy drapes ☐ Venetian blinds ☐ Bookcase ☐ Quilts/Comforters ☐ Stuffed toys ☐ Plants

Bedroom floor: ☐ Carpet ☐ Hardwood ☐ Linoleum

Type of Mattress: ☐ Spring ☐ Foam ☐ Bunk ☐ Water ☐ Crib ☐ Other:_____

Type of Pillow: ☐ Cotton ☐ Feather ☐ Foam ☐ Polyester ☐ Other:_____

_____ _____ _____

Signature Date Time

_____

Print Name

Specifications

Form Description History Allergy **Current Form Number** AG005

Print

Stock

- ☒ 20# White
- ☐ 60# Pastel _____
- ☐ 2 pt carbonless
- ☐ 3 pt carbonless
- ☐ 4 pt carbonless
- ☐ 5 pt carbonless
- ☐ other carbonless
- ☐ Other Stock_____
- ☐ Special Instructions (see below)

Size

- ☒ 8 ½ x 11
- ☐ 8 ½ x 14
- ☐ 11 x 17
- ☐ Special Instructions (see below)

Sides

- ☐ Front
- ☒ Front & Back

Finishing

Padding

- ☐ Top
- ☐ Left

_____sheets / pad

_____ sheets / pack

Unit Size

- ☐ 25 to a pack
- ☒ 50 to a pack
- ☐ 100 to a pack
- ☐ Special Instructions (see below)

Folding

- ☐ **Letter Fold**
- ☐ Z Fold
- ☐ Special Instructions (see below)

Drilling

- ☐ Long edge std 3 holes
- ☐ Long edge 2 holes
- ☐ Long edge 5 holes
- ☐ Long edge 7 holes
- ☐ Long edge 9 holes
- ☐ Short edge 2 holes
- ☐ Staple, Where _Top Left Corner
- ☐ Special Instructions (see below)

Packaging ☐ **Yes** ☐ **No**

_____units / wrap

Special Instructions:_____