ENT and Allergy Center
University of Missouri Health Care

Patient Label

Allergy History Form

Current Complaint: ____

Approximately when did it start or how long has it been an issue? ______________________________

When you first noticed it, which areas of your body was it located? _____________________________

How would you describe the severity when first noticed? ___Mild ___Moderate ___Severe

Which area(s) of your body is it located currently? ____

How would you describe the severity now? ___Mild ___Moderate ___Severe

How would you describe current state? ___Stable ___Increasing ___Decreasing ___ Unclear

Does it worsen? ____ During work week ____ After weekend

Does it improve? ____ After weekend ____ After holidays/vacations

Do your outbreaks occur: ___ Annually ___Seasonally ___Monthly ____ Unclear

Describe what an outbreak looks like: ____

Have you had previous outbreaks? ___ Yes ___ No Date(s): __________________________

Have you self-treated previous outbreaks? ___ Yes ___ No Date(s): _____________________

Have you been treated by a physician for previous outbreaks? ___ Yes ___ No Date(s): ________

History of Allergic Disorders

___ Asthma ___ Hay Fever ___ Childhood Eczema ___ Urticaria

Food Allergy: ___ Known ___ Suspected Type ________________________________

Other known allergies: ___Nickel/metals ___Flowers/Trees/Grasses ___ Perfume/Fragrance

___ Latex (type I) ___ Insects ___Medicines ___Rubber ___ Animals Other: __________

Suspected allergies: ____

Previous drug reactions: ___ None ___ Yes (drug/date) ______________________________

Family History of:

Allergies and Asthma? ___Yes ___ No Hay Fever? ___Yes ___ No Eczema? ___Yes ___ No

Relationship to you? ____________________ Disease? __________________________

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Home Environment:

Do you live in a/an: ___ Home ___ Apartment/Condo Built after 1980? ___ Yes ___ No

Renovated since 1980? ___ Yes ___ No Location? ___Suburban ___Urban ___ Rural

How long have you lived in your current residence? ____

Any pets? ___ None ___Cats ___ Dogs ___Birds ___Rodents ___ Livestock: _______ Other: ________

Current Animal Contact? ___ Daily ___Rare ___ Occasional Pets in the house? ___ Yes ___ No

Pets/Animals as a Child? ___ None Type: __________________ Contact? ___ Rare ___ Frequent

Symptoms around animals? ___ Yes ___ No Describe:____

Housecleaning frequency? ___ Daily ___Weekly ___ Monthly ___ Occasionally ___ Rarely

Participate in Housecleaning? ___Never ___ Always ___ Occasionally ___ Rarely

Equipment/Materials Used? ____

Help with Laundry? ___ Never ___ Daily ___ Weekly ___ Occasionally Detergent: _________________

Symptoms at home? ___ No ___ Yes Describe: ____

Sports/Hobbies:

___Golf ___Tennis/Racquetball ___ Woodworking ___ Computers ___ Baseball ___ Sewing

___ Football ___Skiing ___ Knitting/Needlework ___ Paper Crafts ___ Ceramics ___ Piano

___ Painting ___ Guitar ___ Running/Hiking ___ Home Repairs ___ Basketball

___ Photography Other: ____

Frequency? ___ Daily ___ Few times weekly ___ Weekends only ___ Rarely Time spent? ____________

Equipment/Materials Used? ____

Symptoms with sports or hobbies? ___ No ___ Yes Describe: __________________________________

Personal Care:

How often do you wash your hands? _______________ Soap Type? _____________________________

How often do you take a bath? ___________________ Soap Type? _____________________________

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How often do you use….

Lotion ______________________________ Creme ______________________________

Cologne/Perfume ____________________ Aftershave __________________________

Shaving Cream ______________________ Hair Coloring _______________________

Toothpaste __________________________ Mouthwash __________________________

Shampoo ____________________________ Conditioner __________________________

Hair Styling Aids _______________________ Nail Conditioner/remover: _____________

Nail Polish ____________________________ Artificial Nails__________________________

Contact Lenses ________________________ Saline/Cleaner: _______________________

Makeup Use: ___ Foundation/Base ___ Blush ___ Eyeshadow ___ Eyeliner ___ Mascara

___ Remover ___ Lipstick/Glass/Liner ___ Concealer ___ Face Powder Other: _____________

Facials: ___ Toner/Astringent ___ Masque ___ Moisturizer/Cream ___ Cleanser Other: _______

Condoms/Diaphragms: ___ Daily ___Weekly ___ Monthly ___ Occasionally ___ Don't Use

Type used: ____

Other personal care products used and how often? ____

Symptoms with Personal care: ____

Jewelry & Tattoos:

Jewelry Type? ___ Earring(s) ___ Ring(s) ___ Bracelet(s) ___ Watch(es) ___ Necklace(s)

Other Piercing(s)? ____

How often do you wear jewelry? ___ Daily ___ Few times weekly ___ Weekends ___Rarely ___ Never

Tattoos? ___Permanent ___ Temporary ___ Henna-based ___ Recent ___ Old

Symptoms with Jewelry or Tattoos: ____

Allergy History Form

Employment History:

Current Employer: ____ In position since (date): ______________

Job Title: ____ In position since (date): ______________

Job Description: ____

Employer when condition started:____

Previous job description and duration: ____

Previous/Current contact with: ___Metals ___Dust ___ Vibration ___ Cold/Heat ___ Fibers

___Chemicals ___Fumes Other: ____

Work Environment: ___Office ___Factory ___ Hospital ___ Construction Site ___ Farming

___Laboratory ___Indoors ___ Outdoors Other: ____

Work Equipment: ___Gloves ___Boots ___ Apron ___ Mask/Respirator ___ Face Shield

___Head Cover ___Badge ___Monitors ___ Overalls Other: _________________________________

Symptoms at work: ____ Since (date): ______________________

Description of work when rash began? ____

Materials used at work? ____

Treated and/or documented at place of employment? ____

What happens to your rash on weekends/holidays/vacations? ___ Same ___ Improves ___ Worsens

Loss of work? ___ No ___ Yes, on dates: ___________ Other workers with same issue? ___ Yes ___ No

Previous compensation claims? ___ No ___ Yes, for ____

Part-time or 2nd job? ___ No ___Yes (job title): ____

Work Environment: ___Office ___Factory ___ Hospital ___ Construction Site ___ Farming

___Laboratory ___Indoors ___ Outdoors Other: ____

Symptoms at 2nd job? ___ Same as above ___ Different: __________________________ Since (date): _____

_______________________________________ __________________ __________________

Provider's Signature Date Time