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