CCOAA ALLERGY HISTORY FORM (Side 1)

DATE:________________

Patient Name: ____ DOB: ________________

Do You have…	yes	no	don't know
Trouble with your skin?			
Eczema			
Hives			
Trouble with your ears?			
Popping			
Itching			
Hearing loss			
Fluid in ears			
Infection / Pain			
Trouble with your throat?			
Soreness / Post nasal drip			
Itching throat/mouth			
Trouble with your eyes?			
Redness			
Itching			
Tearing			
Puffiness			
Trouble with your nose?			
Thin / clear drainage			
Thick / colored drainage			
Nasal itching / rubbing			
Periodic stuffiness			
Constant stuffiness			
Sniffles			
Sneezing			
Mouth Breathing			
Snoring			
Trouble with you chest?			
Wheezing with colds			
Wheezing with dust/animals/pollen			
Wheeze/cough after exercise			
Cough - Productive			
Cough - Loose			
Cough - Constant			
Cough during day			
Cough during night			
Are your symptoms Mild			
Moderate			
Severe			
present most of the time			
present part of the time			
present rarely			
Interferes with your life			
Prevents normal activity			

Which of the following cause or worsen your symptoms?	yes	no	don't kno
Being Indoors			
Being outdoors			
Home			
Work			
Morning			
Afternoon			
Night			
Weather Change			
Wet Weather			
Dry Weather			
Windy Day			
Hot Day			
Cold Day			
Air conditioning			
In Barns			
Damp areas			
Hay / Circus			
Mowing Lawn			
Dusty Environment			
High Air Pollution			
Animals			
Cooking odors			
Smoke			
Soap Powder			
Insecticides			
Paint Fumes			
Perfumes			
Cosmetics			
Dust			
Newspapers			
Wool			
Road Dust			
Milk / Milk products			
Eggs			
Wheat products			
Nuts / beans / seeds			
Chocolate			
Fish			
Meat			
Fruit			
Vegetables			
Alcohol			
Beer			
Wine			
Cheese			
Mushroom			
Aspirin			
Chemicals (list)			

____

____

During what months do you have symptoms?	yes	no	don't know
All months			
January			
February			
March			
April			
May			
June			
July			
August			
September			
October			
November			
December			

Family History:			
Asthma			
Rash			
Itchiness			
Eczema			
Migraines			
Other			

Any relatives with allergies?			
Have you ever had allergy testing?			

Please list your allergies:

Please list your allergy medications:

Do they help?			

Please list other medications:

CCOAA ALLERGY HISTORY FORM (Side 2)

DATE:________________

Patient Name: ____

DOB: ______________

Do you take any of the following medication frequently or daily?	yes	no	don't know
Aspirin			
Cortisone			
Laxatives			
Sedatives			
Birth Control Pills			
Vitamins			
Ointments			
Nose drops / sprays			
Hormones			
Others:			

Do you spend time doing the following?			
Photography			
Carpentry			
Camping			
Sewing			
Gardening			
Painting			
Cooking			
Movies			
List your Hobbies:			
Sports:			
Other:			

Do you have animals at home?			
Have you HAD pets in your home?			
Dog			
Cat			
Bird			
Rodent			
Other			

Do you smoke?			
How many packs/day?			
Any smokers at home?			
Chew tobacco?			
Cigars?			
Did you ever smoke?			
When did you quit?			

Have you ever had any of the following?	yes	no	don't know
High blood pressure			
Heart disease			
Migraine Headaches			
Other headaches			
Sinus disease			
Nasal polyps			
Broken nose			
Nasal surgery			
Deviated septum			
Skin disease			
Hives			
Hay fever			
Asthma			
Bronchitis			
Emphysema			
Underactive thyroid			
Hyperactive thyroid			
Hormonal difficulty			
Stomach disease			
Food allergy			
Drug allergy			
Other conditions			

Do you live in a house?			
Apartment/Trailer?			
In the city?			
In the suburbs?			
Is your home New?			
3-10 years old?			
11-25 years old?			
> 25 years old?			

What is your occupation?

Do you think your occupation has anything to do with your symptoms?			

Are there any materials used in your workplace which you think may contribute to your symptoms?

Are you better at work?			
Are you worse?			
Are you the same?			

	yes	no	don't know
Do you sleep with a pillow?			
Is it dacron?			
foam rubber?			
feather?			

Is your mattress:			
Cotton?			
Feather?			
Foam rubber?			
Horse hair?			
Other			

Do you use a humidifier?			
Do you have an air conditioner?			

Is your heating system:			
Gas?			
Oil?			
Coal?			
Electric?			

Is the heat delivered by:			
Radiators?			
Forced air?			
Electric panels?			

Which symptoms bother you most?

When did your symptoms begin?