MAPLETON HEALTH CENTRE
Allergy & Immunology Program

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PATIENT CASE HISTORY FORM

*please complete all four (4) pages

Date: _____
Patient Name: _____ Age: _____
Address: _____
_____
Occupation: _____
Physician's Name & Contact Information: _____
_____

___ New Consult

___ Allergy Re-test
Date of last test: _____
Reacting Allergens: _____
Current Allergy Serum: _____

****Appropriate skin testing depends on sufficient history taking and allergen section****

I. Present Complaint

1. Description:

___ runny nose
___ nasal congestion
___ itchy eyes
___ itchy palate
___ itchy ears
___ other (please list)
_____
_____

___ shortness of breath
___ urticaria/hives
___ eczema/skin reactions
___ food sensitivity
___ sneezing

2. State frequency of symptoms (daily, periodic, seasonal, etc.): _____
_____

3. State duration of symptoms (minutes, hours, days, weeks, months, etc.) _____
_____

II. Prior or Suspected Diagnosis

___ Seasonal Asthma
___ Hay Fever
___ Perennial Asthma
___ Perennial Rhinitis

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III. Symptom Evaluation

If this is a re-test, please answer the following questions. If this is a new consult, please proceed to section IV.

1. Please rate the improvement of your allergy symptoms since starting your allergy shots using a scale of 1-10 where 1=unchanged and 10=resolved. _____

2. For how long did your receive immunotherapy? _____

3. Did you have any significant reactions after your injections? Please describe. _____
   _____

IV. Events Preceding Present Complaint

1. When did the present complaint first start? _____

2. What happened before the first attacked?
   ___ Change of occupation ___ Change of home
   ___ Infective illness ___ Other _____

V. Allergic History

1. Have you ever suffered from:

___ Infantile Eczema	___ Asthma	___ Bronchitis
___ Perennial Rhinitis	___ Migraine	___ Hay Fever
___ Food Sensitivity	___ Urticaria	___ Edema/Swelling
___ Eczema	___ Anaphylaxis	___ COPD

2. Any significant past medical history (admissions to hospital for severe asthma attack, hypertension treated with beta blockers, surgeries, ongoing medical problems, etc.)?
   _____
   _____
   _____

3. Is there a family history of any blood relatives suffering from the conditions listed above?
   ___ Mother ___ Father ___ Sibling ___ Grandparent ___ Other (specify)
   _____

4. Do you use any medications for allergy relief?
   ___ No ___ Yes (please list): _____
   _____

VI. Screen for Causative Allergens

1. What time of year are your allergy symptoms worse? (check all that apply)
   ___ Spring ___ Summer ___ Autumn ___ Winter ___ All Year

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2. Which months are the most problematic?
   ___ Jan ___ Feb ___ Mar ___ Apr ___ May ___ June
   ___ Jul ___ Aug ___ Sept ___ Oct ___ Nov ___ Dec

3. Are symptoms more severe/frequent:
   ___ Outdoors ___ Indoors ___ Both
   ___ At home ___ At work ___ Both

4. Is your home: ___ in the country ___ in the city
   ___ Old ___ New ___ Damp

   How is your home heated? _____

5. When do the symptoms most often occur?
   ___ At night ___ In bed on waking ___ In the bedroom

6. Is your bedroom:
   ___ Heavily carpeted/curtained
   Does your bedroom have:
   ___ Old ___ New mattress
   ___ Old ___ New pillow
   ___ feather pillow or quilt
   ___ flock mattress, pillow or quilt
   ___ kapok mattress, pillow or quilt

7. Are you often in contact with:
   ___ Birds ___ Horses ___ Cats ___ Dogs ___ Rabbits ___ Sheep
   ___ Cattle ___Other pets (list) _____

8. Are symptoms associated with work or hobbies involving:
   ___ Wood ___ Wool ___ Hay ___ Straw ___ Grain
   ___ Dust (not house dust)

9. If you are a farmer and are exposed to hay/straw, briefly describe how you handle and store this product: _____
   _____

10. Are your symptoms caused by or associated with:
    ___ Plants (specify) _____
    ___ Detergents _____
    ___ Other substances _____

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11. Are your symptoms caused by or associated with certain foods?
    ___ Milk ___ Wheat ___ Egg ___ Other _____
    a. Do symptoms occur immediately after eating or is there a delay?
       ___ Immediate ___ Delay
12. Any drug allergies or sensitivities? _____

13. Any evidence of fungal infections? _____

14. Are you a smoker?
    ___ Yes ___ No ___ Exposed to smoke

15. Any other relevant information? _____
    _____
    _____
    _____
    _____
    _____
    _____