Low Country ENT
EAR, NOSE & THROAT · HEAD & NECK SURGERY · HEARING AIDS
BALANCE TESTING · ALLERGY TESTING & IMMUNOTHERAPY
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ALLERGY HISTORY FORM

Patient's Name: _____ **DOB:** _____ **Date:** _____
Address: _____ **Phone #:** _____

Do you have any of these symptoms? (Please check all that apply)			
☐ Nasal Congestion	☐ Swollen Lips/Tongue	☐ Shortness of Breath	☐ Eczema
☐ Sneezing	☐ Scratchy/ Itchy Throat	☐ Wheezing	☐ Ear Pressure
☐ Runny Nose	☐ Throat clearing	☐ Asthma	☐ Blocked Ears
☐ Hay Fever	☐ Throat tightness	☐ Itchy skin	☐ Headaches
☐ Sinus Infections	☐ Hoarseness	☐ Hives	☐ Itchy ears
☐ Post Nasal Drainage	☐ Coughing	☐ Skin Rashes	☐ Itchy/Watery Eyes

During which months do your symptoms occur?				
☐ All Year	☐ January ☐ February ☐ March	☐ April ☐ May ☐ June	☐ July ☐ August ☐ September	☐ October ☐ November ☐ December

Are your symptoms made worse by?			
☐ Cats	☐ Indoors	☐ Dust	☐ Others, specify_____
☐ Dogs	☐ Outdoors	☐ Barns/Hay	
☐ Other Animals	☐ Damp Areas	☐ Yard Work	

Have you had previous allergy skin or blood testing?	☐ Yes ☐ No If yes, when? _____ Where? _____
Have you ever been treated with Allergy injections?	☐ Yes ☐ No
If *yes*, did the allergy injections help your symptoms?	☐ Yes ☐ No
How many years were you on allergy injections?	☐ <1 year ☐ 1-3 years ☐ 3-5 years ☐ >5 years

What, if any allergens did you react positive to?

☐ Grass Pollens	☐ Tree Pollens	☐ Weed Pollens	☐ Cat	☐ Dog	☐ Dust Mites	☐ Molds	☐ Cockroaches

☐ Other, *Specify:*

Have you ever been diagnosed with Asthma?	☐ Yes ☐ No
Are you currently taking any of the following?	☐ Antihistamines ☐ Nasal Sprays ☐ Asthma Medication
Has anyone in your immediate family been diagnosed with allergies or asthma?	☐ Yes ☐ No Relation? _____

List of Antihistamines:

☐ Allegra (Fexofenadine)	☐ Claritin (Loratadine)
☐ Atarax or Vistaril (Hydroxyzine)	☐ Phenergan (Promethazine)
☐ Zyrtec (Cetirizine)	☐ Meclizine (Antivert)
☐ Dimetapp(Dipheniramine)	☐ Xyzal (Levocetirizine).
☐ Chlor-Trimeton (Chlorpheniramine)	
☐ Clarinex (Desloratadine)	

List of Nasal Sprays:

☐ Astelin (Azelastine)	☐ Veramyst (Fluticasone Furoate)	☐ Afrin (Oxymetazoline)
☐ Astepro	☐ Flonase (Fluticasone Propionate)	☐ Nasacort AQ (Triamcinolone Acetonide)
☐ Dymista (Azelastine and Fluticasone Propionate)	☐ Atrovent (Ipratropium Bromide)	☐ Flunisolide 0.025% (Flunisolide)
☐ Q-Nasal (Beclomethasone Dipropionate	☐ Nasonex (Mometasone Furoate Monohydrate	☐ Patanase (olopatadine)
☐ Rhinocort (Budesonide)		
☐ Omnaris (Ciclesonide)		
☐ Zetonna		
☐ Nasalcrom (Cromolyn Sodium)		

List of Asthma Medications:

☐ **Accolate (Zarirlukast)** ☐ **Asmanex Twisthaler/Asmanex HFA** ☐ **Perforomist** ☐ **Singulair** ☐ **Xolair** ☐ **Foradil Aerolizer** ☐ **Combivent** ☐ **Duoneb**	☐ **Advair Diskus/Advair HFA** ☐ **Breo ellipta** ☐ **Pulmicort Flexhaler/Pulmicort Respules** ☐ **Spiriva Respimat** ☐ **Xopenex/Xopenex HFA/Xopenex Concentrate**	☐ **Aerospan HFA (Flunisolide)** ☐ **Dulera** ☐ **Qvar** ☐ **Symbicort** ☐ **Zyflo/Zyflo CR**	☐ **Alvesco (Ciclesonide)** ☐ **Flovent HFA/Flovent Diskus/Arnuity Ellipta** ☐ **Serevant Diskus** ☐ **Ventolin HFA/Proventil HFA/Proair HFA/ProAir Respiclick (Albuterol)** ☐ **Prednisone**

SINO-NASAL Outcome Test (SNOT-22)

Please take a moment to take this short test. Below you will find a list of symptoms and social/ emotional consequences of your rhinosinusitis. We would appreciate your answers to the following questions. There are no right or wrong answers, and only you can provide us with this information. Please rate your problems as they have been over the ***past two weeks.*** Please do not hesitate to ask for assistance if needed. Thank you.

1. Consider how severe the problem is when you experience it and how often it happens, please rate each item below on how "bad" it is by circling the number that corresponds with how you feel using this scale:	No Problem	Very Mild Problem	Mild or slight Problem	Moderate Problem	Severe Problem	Problem as bad as it can be		Most Important Items
1. The need to blow nose	**0**	**1**	**2**	**3**	**4**	**5**		**O**
2. Nasal Blockage (congestion)	**0**	**1**	**2**	**3**	**4**	**5**		**O**
3. Sneezing	**0**	**1**	**2**	**3**	**4**	**5**		**O**
4. Runny Nose	**0**	**1**	**2**	**3**	**4**	**5**		**O**
5. Cough	**0**	**1**	**2**	**3**	**4**	**5**		**O**
6. Post-nasal drainage	**0**	**1**	**2**	**3**	**4**	**5**		**O**
7. Thick nasal drainage	**0**	**1**	**2**	**3**	**4**	**5**		**O**
8. Ear Fullness/clogged	**0**	**1**	**2**	**3**	**4**	**5**		**O**
9. Dizziness	**0**	**1**	**2**	**3**	**4**	**5**		**O**
10. Ear Pain	**0**	**1**	**2**	**3**	**4**	**5**		**O**
11. Facial pain/pressure	**0**	**1**	**2**	**3**	**4**	**5**		**O**
12. Decreased Sense of Smell/Taste	**0**	**1**	**2**	**3**	**4**	**5**		**O**
13. Difficulty Falling asleep	**0**	**1**	**2**	**3**	**4**	**5**		**O**
14. Waking up at night	**0**	**1**	**2**	**3**	**4**	**5**		**O**
15. Lack of a good night's sleep	**0**	**1**	**2**	**3**	**4**	**5**		**O**
16. Wake up feeling tired	**0**	**1**	**2**	**3**	**4**	**5**		**O**
17. Fatigue	**0**	**1**	**2**	**3**	**4**	**5**		**O**
18. Reduced Productivity	**0**	**1**	**2**	**3**	**4**	**5**		**O**
19. Reduced Concentration	**0**	**1**	**2**	**3**	**4**	**5**		**O**
20. Frustrated/restless/irritable	**0**	**1**	**2**	**3**	**4**	**5**		**O**
21. Feeling sad	**0**	**1**	**2**	**3**	**4**	**5**		**O**
22. Embarrassed	**0**	**1**	**2**	**3**	**4**	**5**		**O**

2. Please mark the most important items affecting your health (maximum of 5 items) _____ ⇧