PATIENT HEALTH & ALLERGY HISTORY

Patient name: ______________________ ID#: ______________

Date: ______________ Patient age: ________ Sex: ☐ M ☐ F Occupation: ______________

Race: ☐ White ☐ Hispanic ☐ Black/African-American ☐ Asian ☐ American Indian ☐ Other

Existing Conditions:

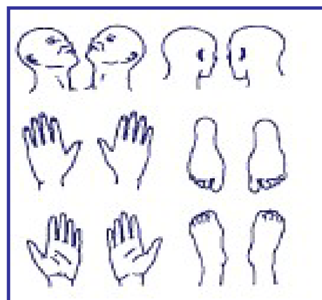
- ☐ Cancer ______________
- ☐ Stroke ______________
- ☐ Cardiovascular Disease ______________
- ☐ Diabetes ______________
- ☐ High Blood Pressure ______________
- ☐ Depression ______________
- ☐ Alcohol/Drug Abuse ______________
- ☐ Liver Disease ______________
- ☐ High Cholesterol ______________
- ☐ Kidney Disease ______________
- ☐ Lung/Respiratory Disease ______________
- ☐ Neurological Disorders ______________
- ☐ Infectious Disease ______________
- ☐ Allergies ______________
- ☐ Pregnancy ______________
- ☐ Menopause: ______________
- ☐ Immune disorders ______________
- ☐ Puberty ______________
- ☐ Obesity ______________
- ☐ Skin Disorders ______________
- ☐ Other ______________

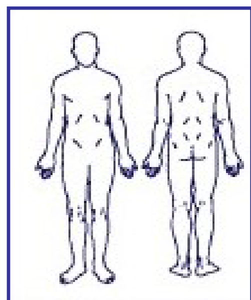
Current Medicines:
OTC & Rx
(dates, dosage)

- ☐ Vitamins/Minerals ______________
- ☐ Herbs ______________
- ☐ NSAIDs ______________
- ☐ Aspirin ______________
- ☐ Asthma Medications ______________
- ☐ Antihistamines ______________
- ☐ Oral contraceptives ______________
- ☐ Thyroxin ______________
- ☐ Sedatives/Sleep Aids ______________
- ☐ Steroids (nasal/topical) ______________
- ☐ Rx Pain Meds ______________
- ☐ Antidepressants ______________
- ☐ Oral hypoglycemics ______________
- ☐ Insulin ______________
- ☐ Hormones ______________
- ☐ Antibiotics/Antifungals ______________
- ☐ Diuretics ______________
- ☐ Other BP Medications ______________
- ☐ Statins ______________
- ☐ Anticoagulants ______________
- ☐ Other ______________

Medical Devices:
(including dental)

- ☐ Implants ______________
- ☐ Stents ______________
- ☐ Braces ______________
- ☐ Fillings ______________
- ☐ Crowns/Bridges ______________
- ☐ Other: ______________





Current Complaint: ______________________________

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Date of onset and/or duration: ______________________________

At onset: Area(s) affected ______________________________

Severity: ☐ Mild ☐ Moderate ☐ Severe

Type and pattern of eruption: ______________________________

____

Now: Area(s) affected ______________________________

Severity: ☐ Mild ☐ Moderate ☐ Severe

Currently: ☐ Stable ☐ Increasing ☐ Decreasing ☐ Unclear

Worsens: ☐ During work week ☐ After weekend

Improves: ☐ After weekend ☐ After holidays/vacations

Outbreaks Occur: ☐ Annually ☐ Seasonally ☐ Monthly ☐ Unclear

Previous Outbreaks: ☐ No ☐ Yes Date(s): ______________

Self-Treat: ☐ No ☐ Yes Date(s): ______________

Physician Treatment: ☐ No ☐ Yes 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 (name)______________________ Disease (name) ______________________

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Home Environment: ☐ Home ☐ Apartment/Condo Constructed after 1980? ☐ Yes ☐ No

Renovated since 1980? ☐ Yes ☐ No Location: ☐ Suburban ☐ Urban ☐ Rural

☐ Other location:______________________ Lived there since:________

Pets: ☐ None ☐ Cats ☐ Dogs ☐ Birds ☐ Rodents ☐ Livestock:__________ Other __________

Current animal contact: ☐ Daily ☐ Rare ☐ Occasional Pets in house? ☐ Yes ☐ No

Pets/animals as a child? ☐ None ☐ Type:____________ Contact: ☐ Rare ☐ Frequent

Symptoms around animals: ☐ No ☐ Yes 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/raquetball ☐ 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 Duration:__________

Equipment/Materials used:______________________________

____

Symptoms with sports/hobbies: ☐ No ☐ Yes Describe:______________________________

Personal Care: ☐ Handwashing frequency:______________ Soap type:______________________

☐ Bathing frequency:______________________ Soap type:______________________

☐ Deodorant use/frequency:______________________ Deodorant type:______________________

☐ Lotion use/frequency:______________________ ☐ Creme use/frequency:______________________

☐ Cologne/perfume use/frequency:______________ ☐ Aftershave use/frequency:______________

☐ Shaving cream use/frequency:______________ ☐ Hair coloring use/frequency:______________

☐ Toothpaste use/frequency: ______________ ☐ Mouthwash use/frequency: ______________

☐ Shampoo use/frequency: ______________ ☐ Conditioner use/frequency: ______________

☐ Hair styling aids use/ frequency: ______________ ☐ Nail conditioner/remover use/frequency:______________

☐ Nails polish use/frequency: ______________ ☐ Artificial nail use/frequency:______________

☐ Contact lenses:______________________ ☐ Saline/cleaner:______________________

Makeup Use: ☐ Foundation/base ☐ Blush ☐ Eyelid powder ☐ Eyeliner ☐ Mascara ☐ Remover
☐ Lipstick/gloss/liner ☐ Concealer ☐ Face Powder ☐ Other:______________________

Facials: ☐ Toner/Astringent ☐ Masque ☐ Moisturizer/Cream ☐ Cleanser ☐ Other____________

Condoms/diaphragms: ☐ Daily ☐ Weekly ☐ Monthly ☐ Occasionally ☐ Don't use

Type:____________________

Other personal care products use/ frequency:____________________

Symptoms with personal care:____________________

Jewelry & Tatoos: Wear ☐ Daily ☐ Few times each week ☐ Weekends ☐ Rarely ☐ Never

Jewelry type ☐ Earring(s) ☐Ring(s) ☐ Bracelet(s) ☐Watch(s) ☐ Necklace(s)

☐ Piercing(s):____________________

Tatoos: ☐ Recent ☐ Old ☐ Permanent ☐ Temporary ☐ Henna-based

Symptoms with jewelry/tatoos:____________________

Employment history: Current employer: ____________________ Since (date):__________

Job title:____________________ Since (date):__________

Job description:____________________

Employer at onset of dermatitis: ____________________

Previous job description and duration:____________________

☐ Previous / ☐ current contact: ☐ 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:____________________

☐ Treat and/or ☐ document at place of employment:____________________

Effect of weekends/holidays/vacations ☐ Same ☐ Improves ☐ Worsens

Loss of work: ☐ No ☐ Yes, on dates:__________ Other workers with same problem? ☐ No ☐ Yes

Previous compensation claims: ☐ No ☐ Yes, for____________________

☐ Part-time or ☐ Second job: ☐ No ☐ Yes, as:____________________

2nd job description:____________________

Work Environment: ☐ Office ☐ Factory ☐ Hospital ☐ Construction site ☐ Farming ☐ Laboratory

☐ Indoors ☐ Outdoors ☐ Other____________________

Symptoms at 2nd job: ☐ same as above ☐ different:__________ Since (date):__________

Notes:____________________