

# Allergy Symptom Timeline Worksheet

Bring this to your telemedicine appointment to help your allergist diagnose faster

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## PATIENT INFORMATION

Name: \_\_\_\_\_

Date: \_\_\_\_\_

Age: \_\_\_\_\_ State: \_\_\_\_\_

Appointment Date: \_\_\_\_\_

## SECTION 1: YOUR PRIMARY SYMPTOMS

Check all symptoms you experience. Circle the 3 worst ones.

NOSE & SINUSES	EYES	THROAT & LUNGS	SKIN
<ul style="list-style-type: none"><li><input type="checkbox"/> Runny nose</li><li><input type="checkbox"/> Stuffy/blocked nose</li><li><input type="checkbox"/> Sneezing fits</li><li><input type="checkbox"/> Post-nasal drip</li><li><input type="checkbox"/> Sinus pressure</li><li><input type="checkbox"/> Reduced smell</li><li><input type="checkbox"/> Nosebleeds</li><li><input type="checkbox"/> Itchy nose</li></ul>	<ul style="list-style-type: none"><li><input type="checkbox"/> Itchy eyes</li><li><input type="checkbox"/> Watery eyes</li><li><input type="checkbox"/> Red eyes</li><li><input type="checkbox"/> Swollen eyelids</li><li><input type="checkbox"/> Dark circles</li><li><input type="checkbox"/> Crusty eyes (AM)</li><li><input type="checkbox"/> Light sensitivity</li></ul>	<ul style="list-style-type: none"><li><input type="checkbox"/> Cough (dry)</li><li><input type="checkbox"/> Cough (with mucus)</li><li><input type="checkbox"/> Wheezing</li><li><input type="checkbox"/> Shortness of breath</li><li><input type="checkbox"/> Chest tightness</li><li><input type="checkbox"/> Throat clearing</li><li><input type="checkbox"/> Sore throat</li><li><input type="checkbox"/> Hoarse voice</li></ul>	<ul style="list-style-type: none"><li><input type="checkbox"/> Hives/welts</li><li><input type="checkbox"/> Eczema/rash</li><li><input type="checkbox"/> Itchy skin</li><li><input type="checkbox"/> Swelling (face)</li><li><input type="checkbox"/> Swelling (hands/feet)</li><li><input type="checkbox"/> Dry/cracked skin</li><li><input type="checkbox"/> Flushing/redness</li></ul>

Other symptoms not listed: \_\_\_\_\_

## SECTION 2: SYMPTOM TIMELINE

This is the most valuable section for your allergist. Be as specific as possible.

QUESTION	YOUR ANSWER
When did symptoms first start? (month/year)	
How long does each episode last? (hours / days / weeks / months)	
How often do symptoms occur? (daily / weekly / seasonal / constant)	
What time of day are symptoms worst? (morning / afternoon / evening / night)	
Which months are worst? (circle): Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec	
Are symptoms year-round or seasonal?	

Do symptoms change when you travel  
or stay in a different home?

### SECTION 3: SUSPECTED TRIGGERS

Check any that seem to make symptoms worse.

OUTDOOR	INDOOR	OTHER
<ul style="list-style-type: none"> <li><input type="checkbox"/> Tree pollen (spring)</li> <li><input type="checkbox"/> Grass pollen (summer)</li> <li><input type="checkbox"/> Weed/ragweed (fall)</li> <li><input type="checkbox"/> Cut grass/lawn mowing</li> <li><input type="checkbox"/> Rain or humidity</li> <li><input type="checkbox"/> Wind</li> <li><input type="checkbox"/> Air pollution/smog</li> <li><input type="checkbox"/> Wildfire smoke</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Dust/vacuuming</li> <li><input type="checkbox"/> Pets: dog / cat / other:_____</li> <li><input type="checkbox"/> Mold/mildew</li> <li><input type="checkbox"/> Smoke (cigarette/fire)</li> <li><input type="checkbox"/> Perfume/fragrances</li> <li><input type="checkbox"/> Cleaning products</li> <li><input type="checkbox"/> New carpet/paint</li> <li><input type="checkbox"/> HVAC running</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Exercise</li> <li><input type="checkbox"/> Cold air</li> <li><input type="checkbox"/> Specific foods:_____</li> <li><input type="checkbox"/> Medications:_____</li> <li><input type="checkbox"/> Stress</li> <li><input type="checkbox"/> Hormonal changes</li> <li><input type="checkbox"/> Insect stings/bites</li> <li><input type="checkbox"/> Unknown</li> </ul>

### SECTION 4: CURRENT & PAST TREATMENTS

List everything you have tried—even OTC products. Note what helped and what did not.

Medication / Remedy	Dose / Frequency	How Long Used	Did It Help? (Yes / Partial / No)

### SECTION 5: QUALITY OF LIFE IMPACT

Rate how allergies affect each area (0 = no impact, 10 = severe impact).

Area	Rating (0–10)	Notes
Sleep quality		
Work / school performance		
Exercise / outdoor activities		
Daily energy / fatigue		
Mood / concentration		

## SECTION 6: RELEVANT MEDICAL HISTORY

Asthma  Eczema  Food allergies  Drug allergies  Sinus surgery  Nasal polyps

Family history of allergies/asthma (who?): \_\_\_\_\_

Pets at home (type, indoor/outdoor?): \_\_\_\_\_

Home type:  House  Apartment  Condo Age of home: \_\_\_\_\_  Carpet  Hardwood

## YOUR QUESTIONS FOR THE ALLERGIST

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

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