

ALLERGY QUESTIONNAIRE

PLEASE MAKE SURE TO FILL OUT THE SECTIONS MARKED WITH ☆ FIRST

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Patient's Name		Date of Birth
Date of Appointment	Referring Physician	



1. INSTRUCTIONS: Please answer the questions as they relate to the person being evaluated. A complete, accurate record is important in learning about your allergy problem. **Bring this completed form to your first appointment.**

Briefly describe the reason for your allergy visit and what you hope to accomplish: _____

2. PROBLEMS (ROS): Have you ever had the following conditions?

Yes	No	(Check all items)	Age at Onset	Severity			Comments
				Mild	Mod.	Sev.	
		Asthma (Wheezing)					
		Any Other Breathing Problems					
		Sinus Trouble					
		Hay Fever (Runny, stuffy, itchy nose, sneezing)					
		Hives or Swelling					
		Eczema or Other Rashes					
		Frequent Infections					
		Food Reactions					
		Drug Reactions					
		Insect Reactions					

3. SYMPTOMS: Have you ever had the following? If not, leave blank.

	How many days in the last month	Severity			Circle the months most severe											
		Mild	Mod.	Sev.	J	F	M	A	M	J	J	A	S	O	N	D
Runny or stuffy nose					J	F	M	A	M	J	J	A	S	O	N	D
Itchy nose					J	F	M	A	M	J	J	A	S	O	N	D
Sneezing					J	F	M	A	M	J	J	A	S	O	N	D
Itchy eyes					J	F	M	A	M	J	J	A	S	O	N	D
Wheezing					J	F	M	A	M	J	J	A	S	O	N	D
Coughing					J	F	M	A	M	J	J	A	S	O	N	D
Wheezing or coughing with exercise					J	F	M	A	M	J	J	A	S	O	N	D
Skin problems					J	F	M	A	M	J	J	A	S	O	N	D

4. PHYSICIAN NOTES:

5. PRECIPITATING FACTORS/TRIGGERS:

For each item below, check the appropriate square to indicate whether your (or your child's) condition is affected by the following precipitants/triggers.

	Condition Made Worse	Condition improved	No Change		Condition Made Worse	Condition improved	No Change
Cutting or playing in grass, raking leaves	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other strong odors Specify:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High winds, riding in auto	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<hr/>			
Other outdoor exposure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Medications:			
Moldy/mildewed areas or items (basement, attic, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	• Antihistamines or cold preparations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sweeping, dusting or vacuuming	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	• Asthma medications	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Smog, smoking or smoke exposure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	• Nose drops or spray How often per day?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Air conditioning or heating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	• Aspirin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cleaning agents, detergents, ammonia, bleach, soap, conditioner, shaving cream, toothpaste, etc. Specify: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	• Other _____			
Paint, lacquer, glue, moth-balls, motor fumes, chemicals, fertilizers, insect spray, cooking odors, etc. Specify: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Exposure to animals Specify:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tobacco smoke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<hr/>			
				"Colds" or viruses	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Physical exertion or exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Cold weather	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Other factors _____			

6. RESIDENCE: List all places lived by city and state, approximate dates, and effects on your problems

City & State	Dates	Effect on Symptoms (better, worse, no change)
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____

7. PREVIOUS ALLERGY EVALUATION AND THERAPY:

Have you ever had allergy skin tests?
 Yes No If yes, date _____ Physician's Name _____

Results of these tests: (If possible, please provide us with a copy)

Have you ever received allergy injections?
 Yes No If yes, give dates: _____

Please list all medications that you are now taking – name, dosage, number of times a day. **Bring these with you for your first appointment.**

Please list all medications you have taken for allergies in the past.



8. OTHER MEDICAL PROBLEMS (ROS): Have you ever had any of the following? Answer all items.

Check all items	Yes	No		Yes	No		Yes	No
Frequent Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	Kidney or Bladder Trouble	<input type="checkbox"/>	<input type="checkbox"/>
Frequent Nosebleeds	<input type="checkbox"/>	<input type="checkbox"/>	Number past year _____			Liver Trouble	<input type="checkbox"/>	<input type="checkbox"/>
Nasal Polyps	<input type="checkbox"/>	<input type="checkbox"/>	Coughed up blood	<input type="checkbox"/>	<input type="checkbox"/>	(e.g. Hepatitis)		
Operation on Sinuses	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>
Sinus X-Rays	<input type="checkbox"/>	<input type="checkbox"/>	Chest X-ray	<input type="checkbox"/>	<input type="checkbox"/>	Bedwetting	<input type="checkbox"/>	<input type="checkbox"/>
Ear Infections	<input type="checkbox"/>	<input type="checkbox"/>	Heart Trouble	<input type="checkbox"/>	<input type="checkbox"/>	Poison Ivy or	<input type="checkbox"/>	<input type="checkbox"/>
Number past year _____			High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Poison Oak	<input type="checkbox"/>	<input type="checkbox"/>
Hearing Problems	<input type="checkbox"/>	<input type="checkbox"/>	Colic or Spitting Up	<input type="checkbox"/>	<input type="checkbox"/>	Other _____	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	As An Infant			_____		
Tonsils/Adenoids	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Heartburn	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Removed (date) _____			Diabetes	<input type="checkbox"/>	<input type="checkbox"/>			

9. IMMUNIZATION: (List dates and reactions, if any, for children only)

Polio _____	Measles _____
DPT _____	Rubella (German Measles) _____
Tetanus Booster _____	Influenza _____
Other (Pneumo-vax) _____	

10. HOSPITALIZATIONS:

List most recent first	Reason	Date
1. _____		
2. _____		
3. _____		
4. _____		
5. _____		

11. SURGERY:

List most recent first	Reason	Date
1. _____		
2. _____		
3. _____		
4. _____		
5. _____		

12. FAMILY HISTORY:

Do any members of your family have a history of allergy?

	Yes	No	If yes, list all relatives (e.g. parents, brothers, sisters, children, aunts, uncles, grandparents, etc.)
Asthma			
Hay Fever			
Eczema			
Hives			
Swelling			
Frequent Pneumonia			
Headaches			
Other Allergies			

Is there a family history of any other illnesses?			
	Yes	No	If yes, list all relatives
Emphysema or Other Lung Disease			
Cystic Fibrosis			
Tuberculosis			
Thyroid Disease			
Glaucoma			
Diabetes			
Other			



13. ENVIRONMENTAL SURVEY:

Which city do you live in? <input type="checkbox"/> Rural Setting <input type="checkbox"/> City Setting		Number of indoor plants	
Age of house _____ years		House construction (brick, wood, etc.)	
Are any rooms damp or musty?		Do you have: (a) an air cleaner? (b) an air dehumidifier?	
Type of heating (forced air, steam, spaceheater, baseboard, electric, etc.)		Type of air conditioning (central, window, etc.)	
Type of Carpet (wool, synthetic, jute) _____ carpet	Bedrooms	Living Room	Family Room
And Pad (rubber, ozite, hair) _____ pad			Dining Room
How old is your: Pillow? _____ Mattress? _____		Do you have any: Stuffed furniture? Feather comforters?	
Is your pillow: <input type="checkbox"/> feather <input type="checkbox"/> dacron <input type="checkbox"/> encased in plastic <input type="checkbox"/> foam rubber <input type="checkbox"/> other _____		Is your mattress: <input type="checkbox"/> foam rubber <input type="checkbox"/> cotton <input type="checkbox"/> innerspring & cotton <input type="checkbox"/> waterbed <input type="checkbox"/> encased in plastic <input type="checkbox"/> other _____	
What plants, if any, contribute to your symptoms?			
Do you have pets? List number and kind (dog, cat, birds, horses, etc.) How long?		Do your pets spend time indoors? <input type="checkbox"/> Yes <input type="checkbox"/> No	
What type of work do you do?			
Are you exposed to anything at work that might aggravate your condition? Which things?			
Have you missed any time from work or school because of your allergies? How much time?			
Do you have any other exposures from hobbies, recreations, activities, etc.?			

14. CURRENT MEDICATIONS: (Include aspirin, vitamins, birth control pills, etc.)

15. ARE YOU ALLERGIC TO ANY MEDICATIONS?:

YES NO What? _____

16. SMOKING / WEIGHT:

Have you ever smoked? Yes No
If yes, how many years? _____

Do you presently smoke? Yes No
When did you stop? _____

Average cigarettes per day at highest point? _____

If you still smoke, do you think you could stop? Yes No
Which other family members now smoke?

Weight now: _____ Weight one year ago: _____
Maximum weight: _____ When? _____

BRING THIS COMPLETED FORM WITH YOU FOR YOUR FIRST APPOINTMENT. THANK YOU.