ALLERGY QUESTIONNAIRE

Patient 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: Have you ever had the following conditions?

Yes	No	(Check all items)	Age of Onset	Mild	Moderate	Severe
___	___	Asthma (Wheezing)	_____	_____	_____	_____
___	___	Any other breathing problems	_____	_____	_____	_____
___	___	Sinus troubles	_____	_____	_____	_____
___	___	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 any of the following? (If not, please leave blank.)

	Days in last Month?	Mild	Moderate	Severe	Circle the months most severe
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) FOOD REACTIONS: Have you ever had any symptoms (rash, hay fever, vomiting, gas, cramps, diarrhea, colic as an infant) after the ingestion of any food or liquid? If yes, specify below.

Food	Approx. Date	Symptoms	Can food be eaten?	Date food was last eaten.
_____	_____	_____	____Y____N	_____
_____	_____	_____	____Y____N	_____
_____	_____	_____	____Y____N	_____
_____	_____	_____	____Y____N	_____

5) PRECIPITATING FACTORS/TRIGGERS

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

	Condition made worse	**Condition improved**	**No change**
Cutting or playing in grass. Raking leaves	_____	_____	_____
High winds, riding in auto	_____	_____	_____
Other outdoor exposure	_____	_____	_____
Moldy/mildewed areas or items (basement, attic, etc.)	_____	_____	_____
Sweeping, dusting, or vacuuming	_____	_____	_____
Air conditioning or heating	_____	_____	_____

	Condition made worse	**Condition improved**	**No change**
Cleaning agents, detergents, ammonia, bleach, soap, conditioner, shaving cream, toothpaste, etc. Specify:_____	_____	_____	_____
Paint lacquer, glue, mothballs, motor fumes, chemicals, fertilizers, insect spray, cooking odors, etc. Specify:_____	_____	_____	_____
Tobacco smoke	_____	_____	_____
Other strong odors (Specify:_____	_____	_____	_____
Medications:			
Antihistamines or cold preparations	_____	_____	_____
Asthma medications	_____	_____	_____
Nose drops or spray (How often?_____)	_____	_____	_____
Aspirin	_____	_____	_____
Other:_____	_____	_____	_____
Exposure to animals (Specify _____	_____	_____	_____
"Colds" or viruses	_____	_____	_____

6) RESIDENCE: List your past residences, with your most recent first. Only city and state required

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

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 all these with you for your first appointment.

_____

_____

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

_____

_____

_____

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

Frequent Headaches	___Yes___No	Pneumonia (# in past year_____)	___Yes___No	Kidney or bladder trouble	___Yes___No
Frequent nosebleeds	___Yes___No	Coughed up blood	___Yes___No	Liver trouble (hepatitis)	___Yes___No
Nasal polyps	___Yes___No	Tuberculosis	___Yes___No	Frequent diarrhea	___Yes___No
Operation on sinuses	___Yes___No	Chest X-ray	___Yes___No	Sexual problems	___Yes___No
Ear infections # in past year_____	___Yes___No	Heart trouble	___Yes___No	Bedwetting	___Yes___No
		Diabetes	___Yes___No	Glaucoma	___Yes___No
High blood pressure	___Yes___No	Poison ivy or oak	___Yes___No	Tonsils/adenoid removed? Date:	___Yes___No _____
Colic or spitting up as an infant	___Yes___No				
Frequent Heartburn	___Yes___No	Other: _____			

9) IMMUNIZATIONS: (List dates and reactions, if any)

Polio _____ Measles _____
DPT_____ Rubella (German Measles) _____
Tetanus Booster _____ Influenza_____
Other (Pneumo-vax) _____

10) HOSPITALIZATIONS:

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

11) SURGERY:

List most recent first	Reason	Date
1.		
2.		
3.		

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, grandparents, etc.)
Allergy	___	___	
Asthma	___	___	
Hay Fever	___	___	
Eczema	___	___	
Hives	___	___	
Swelling	___	___	
Headaches	___	___	
Other Allergies	___	___	
Pneumonia	___	___	
Emphysema or other Lung Disease	___	___	
Cystic Fibrosis	___	___	
Tuberculosis	___	___	
Thyroid Disease	___	___	
Glaucoma	___	___	
Diabetes	___	___	
Other	___	___	

ENVIRONMENT

Number of people living in home: _____ Adults _____ Children _____

Residence: house, condo, apartment, mobile home, duplex, trailer, other _____

Age of building: _____ Number of years lived there _____

Location: town, rural, suburban, near freeway, beach, near factory, horses or cattle nearby.

Pets: none, dog, cat, horses, bird, rabbit, other _____

Kept: indoors, outdoors, in bedroom. Sleeps in _____

General Irritants

Smokers _____

Leaks or Molds: none

Use of Aerosols: none, insecticides, paint, hairspray, deodorant, room deodorant, other _____

Exposure to chemicals: none, _____

Type of filter:

Type of heater: forced-air, gas wall, fireplace, electric, other _____

Vaporizer or humidifier

Air conditioning: wall unit, central disposable filter, washable filter, frequency changed or cleaned _____

Swamp cooler: how frequently is the water changed: _____

Type of filter:

Number of house plants _____ , number in bedroom _____ , number in wicker baskets _____

Dried plants _____ , Fresh flowers _____

Wall hangings:

Furniture: kapok, wool, feather, down, animal hair, antiques, what room _____

Carpeting: wall-to-wall, throw rugs, rug pads made of animal hair

Toiletries are kept in: bathroom, bedroom, other _____

Bedroom

Own, share

Pillow: synthetic, foam, feather, other _____

Sheets and blankets: cotton, synthetic, wool, down, other _____

Drapes and curtains: cotton, synthetic, other _____

Blinds or levelors: Desk: Bookshelves:

Plastic encasings: none, pillow, mattress, box spring

Neat & tidy, untidy, unkempt, messy

Lots of knick-knacks, few, none.

Books, papers, toys, stuffed animals, paints, other _____

Closets: stores books, toys, only clothes, other _____
left open, kept closed, boxes, misc.

Windows: open/closed, day/night, seasonal/year round

Flora: _____