

ALLERGY QUESTIONNAIRE

Please bring this completed form to your first appointment.



Name _____ Date _____

Appointment Date _____ Date of Birth _____ Referring Physician _____

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1. Instructions

Answer the questions as they relate to the person being evaluated. A complete, accurate record is important in learning about your allergy problem.

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 at Onset	Severity			Comments
				Mild	Mod.	Sev.	
		Asthma (Wheezing)					
		Other Breathing Problems					
		Sinus Trouble					
		Hay Fever (runny, stuffy, itchy nose; sneezing)					
		Hives or Swelling					
		Eczema of Other Rashes					
		Frequent Infections					
		Food Reactions					
		Drug Reactions					
		Insect Reactions					
		Reaction to Latex/Rubber					
		Contact Allergy (Metals, Chemicals)					

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 w/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 you (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"/>	Tobacco Smoke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High winds, riding in auto	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other strong odors Specify: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other outdoor exposure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Medications:			
Mold/mildew 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"/>	• Other _____			
Cleaning agents, detergents, ammonia, bleach, soap, conditioner, shaving cream, toothpaste etc. Specify: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Exposure to animals Specify: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Paint lacquer, glue, mothballs, motor fumes, chemicals, fertilizers, insect spray, cooking odors, etc. Specify: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	"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, list dates _____

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

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

8. Other Medical Problems:

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, number past year _____	<input type="checkbox"/>	<input type="checkbox"/>	Kidney or Bladder Trouble	<input type="checkbox"/>	<input type="checkbox"/>
Frequent Nosebleeds	<input type="checkbox"/>	<input type="checkbox"/>	Coughed up Blood	<input type="checkbox"/>	<input type="checkbox"/>	Liver Trouble (e.g. Hepatitis)	<input type="checkbox"/>	<input type="checkbox"/>
Nasal Polyps	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>
Operation on Sinuses	<input type="checkbox"/>	<input type="checkbox"/>	Chest X-ray	<input type="checkbox"/>	<input type="checkbox"/>	Bed Wetting	<input type="checkbox"/>	<input type="checkbox"/>
Sinus X-rays	<input type="checkbox"/>	<input type="checkbox"/>	Heart Trouble	<input type="checkbox"/>	<input type="checkbox"/>	Poison Ivy or Poison Oak	<input type="checkbox"/>	<input type="checkbox"/>
Ear Infections number past year _____	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Other _____		
Hearing Problems	<input type="checkbox"/>	<input type="checkbox"/>	Colic or Spitting up as an Infant	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Heartburn	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Tonsils/Adenoids	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Removed (date) _____								

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			

Family History (cont.): 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

Where do you live? (City or Rural) _____	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, or (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) Bedrooms _____	Type of Carpet Pad? (Rubber, ozite, hair) Bedrooms _____
Living Room _____	Living Room _____
Family Room _____	Family Room _____
Dining Room _____	Dining Room _____
How old is your pillow? _____	How old is your mattress? _____
Do you have any stuffed furniture? _____	Do you have any feather comforters? _____
Is your pillow: feather <input type="checkbox"/> dacron <input type="checkbox"/> foam rubber <input type="checkbox"/> in plastic <input type="checkbox"/> other: _____	Is your mattress: innerspring & cotton <input type="checkbox"/> cotton <input type="checkbox"/> water bed <input type="checkbox"/> foam rubber <input type="checkbox"/> encased in plastic <input type="checkbox"/> other: _____
What plants, if any, contribute to your symptoms? _____	
Do you have pets? Yes <input type="checkbox"/> No <input type="checkbox"/>	
List number and kind of all animals _____	Do they spend time indoors? _____
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 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?

Please list: _____

16. Smoking/Weight

Have you ever smoked? Yes No How long? _____

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

Average per day at highest point? _____

If you still smoke, do you think you can stop? Yes No

Which other family members smoke? _____

Weight now: _____ One year ago: _____

Maximum Weight. _____ When? _____