ALLERGY QUESTIONNAIRE

How were you referred? Physician (name) _____ Self referral _____ Other _____

What Problem brings you or your child to this appointment? _____

_____

_____

When did symptoms begin? _____

Are your symptoms getting worse? ❑ Yes ❑ No

Do you have any of these symptoms? (Please check)

❑ Cough	❑ Runny Nose	❑ Nasal Polyps	❑ Eczema
❑ Wheezing	❑ Nasal Congestion	❑ Poor Sense of Smell	❑ Hives / Swelling
❑ Shortness of breath	❑ Itchy Nose	❑ Ear Infections	❑ Headaches
❑ Chest tightness	❑ Itchy / Watery Eyes	❑ Sinus Infections	❑ Snoring
❑ Sneezing	❑ Postnasal Drip	❑ Blocked Ears	❑ Fatigue
	❑ Phlegm /Sputum (color) _____		❑ Other

Check any of the following which seem to trigger (or cause) symptoms or bother you:

❑ Grass	❑ Cats	❑ Cosmetics	❑ Drafts	❑ Nervousness
❑ Hay	❑ Dogs	❑ Aerosol sprays	❑ House dust	❑ Cold Air
❑ Mold and Mildew	❑ Horses	❑ Perfumes	❑ Smoke	❑ Humidity
❑ Basements	❑ Other animals	❑ Insecticides	❑ Pollution	❑ Weather changes
❑ Leaves	❑ Alcoholic beverages	❑ Odors	❑ Exercise	❑ Latex (rubber)

Other _____

When are your symptoms worse? ❑ Year Round

❑ January	❑ February	❑ March	❑ April	❑ May	❑ June
❑ July	❑ August	❑ September	❑ October	❑ November	❑ December

Are symptoms better away from home? ❑ Yes ❑ No If Yes, when? _____

Have you been skin tested? ❑ Yes ❑ No

Results: _____

Have you had allergy injections? ❑ Yes ❑ No When: _____

Have you received cortisone (prednisone, methylprednisolone, etc.) drugs? ❑ Yes ❑ No

When _____ How much: _____

Occupation (current or former) _____

Any harmful exposure at work or school: _____

ENVIRONMENTAL SURVEY

How long have you lived in your house/apartment? _____

Do you live in a ❑ House ❑ Apartment/Duplex ❑ Condominium/Townhouse

Approximately how old is your house/apartment/condo? _____

Do you live ❑ In the city ❑ In the suburbs ❑ Rural areas

Do you have a basement? ❑ Yes ❑ No

Is your house built on a slab? ❑ Yes ❑ No

Type of heating system (check one) ❑ Hot Air ❑ Steam (radiator) ❑ Electric ❑ Hot water (baseboard)

Do you have: ❑ Wood /Coal Stove ❑ Humidifier ❑ Dehumidifier ❑ Air cleaner

Pets (number) – Indoor or Outdoor ❑ None ❑ Cats ____ ❑ Dogs ____ ❑ Birds ____ ❑ Other _____

Are there any tobacco smokers in your home? ❑ Yes ❑ No

Is your bedroom in the basement? ❑ Yes ❑ No

Do Not Write in this Section

-Turn Over-

Do you have allergy proof encasing for pillow or mattress ❑ Yes ❑ No
What type of pillows do you have? _____
What type of comforter do you have? _____
What type of floor covering do you have **in your bedroom**? ❑ Wall to wall ❑ Area Rug ❑ Animal skin ❑ Bare floor
How old is your mattress? _____What is in your mattress (i.e. cotton/horse hair) _____
Do you have air conditioning? ❑ Yes ❑ No If Yes, ❑ Window Unit ❑ Central
Do you have problems with roaches or mice ❑ Yes ❑ No
Do you have water leaks, mold contamination? ❑ Yes ❑ No
Is your home/apartment excessively humid? ❑ Yes ❑ No

YOUR PAST MEDICAL HISTORY

Check all that apply:

❑ Diabetes	❑ Liver disease/hepatitis	❑ Peptic ulcer	❑ Heartburn/reflux
❑ Cancer	❑ Heart problems/murmur	❑ Thyroid disease	❑ Seizures
❑ High blood pressure	❑ Osteoporosis	❑ Arthritis	❑ Migraines
❑ Anemia/blood disorder	❑ Asthma	❑ Hay fever	❑ Depression
❑ Kidney/bladder disease	❑ Gynecologic problems	❑ Diarrhea	❑ Anxiety
❑ Back problems	❑ Glaucoma	❑ Cataracts	❑ Loss of hearing
			❑ Emphysema

If yes to any of the above, please explain:

_____

_____

Have you had your tonsils or adenoids removed? ❑ Yes ❑ No
Have you had ear, nose or sinus surgery ❑ Yes ❑ No
If Yes, please explain _____

_____

_____

FAMILY HISTORY

Who in your family has had: (**NOT** including yourself)

❑ Asthma _____
❑ Eczema _____
❑ Seasonal /year round allergies _____
❑ Other allergies (drugs/bee sting/food etc) _____
❑ Sinus problems _____

Please list any hospitalizations regardless of cause: _____

_____

_____

List any food allergies and reactions experienced: _____

_____

_____

List any drug allergies and reactions experienced (i.e. penicillin, aspirin, sulfa, latex, etc.): _____

_____

Describe any reaction to insect stings: _____

_____

List all medications and dosages (including nasal sprays, non-allergy medications and alternative/herbal products):

_____

_____

_____

_____

Do you smoke? ❑ Yes ❑ No How much? _____
Have you smoked in the past? ❑ Yes ❑ No When stopped? _____
If Yes, how many years have you smoked? _____

Patient Name: _____ Clinic #: _____

Date: _____ Questionnaire reviewed: _____

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Do Not Write in this Section

BW:

P/L/D:

BF:

Grade: