MANDEL R. SHER, M.D.
11200 Seminole Blvd Suite 310, Largo, FL 33778
727-397-8557

ALLERGY QUESTIONAIRE

Patient's Name: _____ Date of Birth: _____

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. Please bring this completed form to your first appointment.**

1. Briefly, describe the reason for your allergy visit and what you hope to accomplish:

_____

_____

2. PROBLEMS: Have you ever had the following problems or conditions?

Yes	Check all items that apply	Age at onset	Severity Mild, Moderate or Severe	
	Asthma			
	Any other breathing problems			
	Sinus trouble			
	Hay Fever (Nasal Allergies)			
	Hives or swelling			
	Eczema or other rashes			
	Frequent infections			
	Insect reactions			
	Latex Allergy			
	Metal Allergy			

3. SYMPTOMS (ROS): Are you having any of the following? Circle all that apply and please indicate frequency

NASAL & SINUS (ENT)
Runny Nose
(One side or both)
Stuffy Nose
(One side or both)
Discolored nasal drainage
Post Nasal Drip
Itchy Nose
Sneezing
Throat clearing
Cough
Hoarseness
Bad Breath
Sore Throat
Nose Bleeds
Nasal Polyps

Sinus
Loss of Smell
Decreased Sense of Smell
Mouth Breathing/Snoring
Sleep Apnea
(Stop breathing during sleep)
Sinus Pain
Sinus X-Rays
Head or Sinus CT Scan

Eyes
Itching
Redness
Watery
Dark Circles
Dry Eyes

Gastrointestinal
Heartburn
Acid Reflux

Chest
Cough with Exercise
Cough with Laughter
Cough- middle of night
Cough- lying down
Cough upon awakening
Shortness of Breath
Wheezing
Chest Tightness

Skin
Rash
Swelling
Itching
Bruising
Dry Skin
Eczema
Hives

Infections
Ear Infections
Throat Infections
Sinus Infections
Pneumonia
Bronchitis
Other Infections

Headaches
Frequent Headaches
Severity_____
Triggers_____
Pressure
Unilateral
Bilateral
Visual Distributions
Nausea
Vomiting

Are symptoms present year round? _____

Is there a time of year that symptoms are worse? _____

4. PRECIPITATING FACTORS/TRIGGERS: For each item below, check the appropriate square to indicate whether symptoms or condition is affected by the following precipitants/trigger.

Condition is made:	WORSE	IMPROVED	NO CHANGE		WORSE	IMPROVED	NO CHANGE
Cutting or playing in grass or raking leaves				Paint lacquer, glue, mothballs, motor fumes, chemicals, fertilizers, insect spray, cooking odors, etc. Specify type:			
High winds, riding in auto				Trips away from home			
Other outdoor exposure				Other strong odors (perfumes, etc.) Specify type:			
Mold or mildewed areas				Exposure to animals: Specify:			
Sweeping, dusting or vacuuming				"Colds" or viruses			
Smog, smoking or smoke exposure				Physical exertion or exercise			
Air conditioning or heating				Cold weather			
Cleaning agents, detergents, ammonia, Bleach, soap, conditioner, shaving cream, Toothpastes, etc. Specify:				Other Factors:			

5. 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, liquid, MSG, Sulfites, or food coloring? If yes, please give details below.

FOOD	DATE	SYMPTOMS	Can food be eaten? Yes	No	DATE FOOD WAS LAST EATEN.

6. PREVIOUS ALLERGY EVALUATION AND THERAPY

Have you ever had allergy skin tests? ☐ Yes ☐ No If yes, date (How long ago) _____ Physician's Name: _____

What were the results of these tests: _____

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

Did your symptoms improve while you received shots? ☐ Yes ☐ No

Did you ever experience an adverse reaction to an allergy injection? ☐ Yes ☐ No

If yes, please specify: _____

Do you or have you ever used over the counter nasal sprays? ☐ Yes ☐ No

If yes, please specify: _____

List all medication(s) you have taken for allergies in the past:

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

7. DRUG/MEDICATION/IMMUNIZATION ALLERGIES & INTOLERANCES:

List all drug allergies and the reactions (hives, rash, nausea, vomiting, diarrhea, difficulty breathing, etc.)

1._____ 4._____

2._____ 5._____

3._____ 6._____

8. MEDICATIONS (INCLUDING OVER-THE-COUNTER):

MEDICATION NAME	STRENGTH	DAILY FREQUENCY	MEDICATION NAME	STRENGTH	DAILY FREQUENCY

9. MEDICAL HISTORY HAVE YOU HAD OR BEEN DIAGNOSED WITH (CHECK ALL THAT APPLY)?

□ Anemia	□ Diabetes Type 1 or Type 2:	□ Irritable bowel syndrome	□ Osteopenia/ Osteoporosis
□ Anxiety	□ Fibromyalgia	□ Jaundice/liver disease	□ Pneumonia/Lung Disease
□ Arthritis Osteo or Rheumatoid?	□ Glaucoma	□ Kidney disease	□ Prostate Problems
□ Atrial fibrillation	□ GERD/heartburn	□ Low back pain	□ Seizures/Epilepsy
□ Bleeding disorder	□ Heart attack	□ Migraines/Headache	□ Sleep Apnea
□ Cancer What kind?	□ Heart disease	□ Menopause	□ Sleep Disturbance
□ Cataracts	□ Heart failure	□ Menstrual Irregularities	□ Thyroid disease
□ Colon polyps	□ High blood pressure/hypertension	□ Neuropathy	□ Ulcers
□ Depression	□ High cholesterol	□ Obesity	□ Urinary Incontinence
Other:			

10. HEALTH MAINTENANCE (LIST IF/WHEN LAST PERFORMED):

Bone density test: _____

Colonoscopy: _____

Endoscopy:_____

Flu Vaccine:_____

Meningococcal Vaccine: _____

MMR Vaccine: _____

Pneumonia Vaccine: _____

Shingles Vaccine: _____

Tetanus Vaccine:_____

11. Surgical History (List any surgeries or procedures you have had performed):

WHAT	DATE	WHAT	DATE

12. HOSPITALIZATIONS (List ANY hospitalizations):

WHY?	DATE	WHY?	DATE

13. FAMILY HISTORY: Please indicate if your blood relative (s) have had/currently have the following

Family Member	Alive	Deceased	Year of birth/Age	Asthma	Allergic Rhinitis/ Hay fever	Food Allergy	Drug Allergy	Diabetes	Hypertension/ High blood pressure	Heart disease	Mental Illness	Unknow History
Mother												
Father												
Son(s)												
Daughter(s)												
Sibling(s)												
Other: Please Specify												

14. Review of Systems. Please circle all that apply.

Fatigue	Diarrhea	Weakness	Irregular Heartbeat
Fever	Vomiting	Fainting	Abdominal Pain
Disordered Sleep	Bruising	Anxiety	Joint Pain
Weight Changes	Bleeding	Depression	Constipation
Muscle Pain	Urinary Urgency	Urinary Frequency	

15. BIRTH HISTORY: Please complete the following for dependent children under 18 years of age.

Place of Birth:_____ Age of mother at birth:_____

Was pregnancy normal: ☐ Yes ☐ No If no, please specify reason: _____

_____

Was delivery by: ☐ C-Section ☐ Vaginal Patient was: ☐ Formula fed ☐ breast fed

In the first year of life were any of the following present? ☐ Colic ☐ Spit up a lot ☐ Rash ☐ Eczema

Was patient born with pets present in the home? ☐ Yes ☐ No (If Yes, please list): _____

16. MARITAL STATUS: ☐ Married ☐ Single ☐ Widowed ☐ Separated ☐ Divorced Number of Children:_____

17. RESIDENCE: List your past residences with your most recent first. List only city and state.

	City & State	How Long	Symptoms better	Symptoms worse	No Change
1.					
2.					
3.					

18. WORK ENVIRONMENT:

What type of work do you do? _____ Where are you employed? _____

Is your work environment: ☐carpeted ☐ tiled Are you exposed to chemicals or strong odors or anything that might aggravate your condition?

If yes, please specify: _____

19. SCHOOL ENVIRONMENT:

What school do you attend? _____

What Grade? _____

Have you missed school because of your allergies? _____ How many days in the last year? _____

Do you feel extra-curricular activities have been affected by allergies?

_____

20. ENVIRONMENTAL SURVEY:

Approximate age of house:	How old is your _____pillow? _____Mattress?
Are any rooms damp or musty?	Is your pillow: ☐ feather ☐ foam rubber ☐ Dacron ☐ encased in plastic ☐ other:
Type of heating? (electric, gas, central, etc.)	Is your mattress: ☐ innerspring ☐ foam rubber ☐ Waterbed ☐ encased in plastic ☐ other:
Do you have: ☐ Air Cleaner ☐ Air dehumidifier	Are your sheets washed in: ☐ cold ☐ warm ☐ hot water
How often do you change/clean your air conditioner and air cleaner filters?	Do you have any: ☐ Stuffed furniture ☐ Feather comforters ☐ stuffed animals
Is the home: ☐ carpeted ☐ tiled Is bedroom: ☐ carpeted ☐ tiled	Do you have pets? (List number and kind. dog, cats, birds, horses etc.):
	Other:

Please circle yes or no

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

Do you presently smoke? Yes No

If no, when did you stop_____ Average cigarettes per day at highest point?_____

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

Do you or family members smoke: In the house? _____ In the car ? _____

Which other family members now smoke?_____

Do you drink alcohol? Yes No

If yes, list _____

Average weekly consumption (times per week):_____

Do you consume caffeine? Yes No
If yes, how many caffeine drinks do you consume per day? _____

Do you use drugs other than for medical reasons? Yes No