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ALLERGY QUESTIONNAIRE

*** PLEASE DO NOT PLACE YOUR NAME OR DATE OF BIRTH ON THIS FORM ***

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)	SINUS	Eyes	Gastrointestinal	Chest	Skin	Infections	Headaches
Runny Nose (One side/ both)	Loss of Smell Decreased Sense of smell	Itching Redness Watery	Heartburn	Cough w/ Exercise	Rash Swelling Itching	Ear Infections Throat Infections Sinus Infections	Frequent Headaches
Stuffy Nose (One side/ Both)	Mouth Breathing/ Snoring Sleep Apnea (Stop breathing during sleep)	Dark Circles Dry Eyes	Acid Reflux	Cough w/ Laughter Cough- middle of night Cough-lying	Bruising Dry Skin Eczema Hives	Pneumonia Bronchitis Bronchitis Other Infections	Severity _____ Triggers _____ Pressure
Discolored nasal drainage	Sinus Pain Sinus X-Rays			Down Cough upon			Unilateral Bilateral
Post Nasal Drip Itchy Nose Sneezing	Head or Sinus CT Scan			awakening Shortness of Breath			Visual distributions Nausea
Throat Clearing Cough				Wheezing Chest			Vomiting
Hoarseness Bad Breath				tightness			
Sore Throat Nose Bleeds							
Nasal Polyps							

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.			
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 healing				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

Circle Yes or No:

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 / Headaches	○ 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: _____

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	WHAT	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	Unknown history
Mother												
Father												
Sons(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 animals / Feather comforters / Stuffed furniture
Is the home: carpeted / tiled Is bedroom: carpeted / tiled	Other:

Please circle yes or no:

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

Do you presetly 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