SHER ALLERGY SPECIALISTS
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			
	Food reactions			
	Drug reactions			
	Insect reactions			
	Latex Allergy			
	Metal Allergy			

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

NASAL & SINUS **(indicate frequency)**

Runny Nose (One side vs both)
Stuffy Nose (One side vs both)
Discolored nasal drainage
Post Nasal Drip
Itchy Nose
Sneezing
Throat clearing
Cough
Hoarseness
Bad Breath
Sore throat
Nose Bleeds
Nasal Polyps
Loss or Decrease Sense of Smell
Mouth Breathing/Snoring
Sleep Apnea (stop breathing during sleep)
Sinus X-Rays
Head or Sinus CT Scan

EYES **(indicate frequency)**

Itching
Redness
Watery
Dark Circles
Dry eyes

CHEST **(indicate frequency)**

Cough with Exercise
Cough with Laughter
Cough middle of night
Cough Lying Down
Cough upon awakening
Shortness of Breath
Wheezing
Chest Tightness
Nighttime Waking
Heartburn
Acid Reflux
Chest Pain
Chest X-ray

SKIN **(indicate frequency)**

Rash
Swelling
Itching
Bruising
Dry Skin
Eczema
Hives

INFECTIONS **(indicate frequency)**

Ear Infections
Throat Infections
Sinus Infections
Pneumonia
Bronchitis
Other Infections

HEADACHES

Frequent headaches
Severity ____________________
Triggers ____________________
Pressure
Unilateral
Bilateral
Visual Disturbances
Nausea
Vomiting

Are symptoms present year round? ______________________________

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

4. MEDICATIONS:

List all medications that you are currently taking (name, strength, number of times a day):

1.______________________ 6.______________________

2.______________________ 7.______________________

3.______________________ 8.______________________

4.______________________ 9.______________________

5.______________________ 10.______________________

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

1.______________________ 4.______________________

2.______________________ 5.______________________

3.______________________ 6.______________________

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

If yes, please specify:______________________

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. 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:			

7. 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.					

8. 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:____

9. OTHER MEDICAL PROBLEMS: Have you ever been diagnosed with or had any of the following? Circle all that apply

Hearing Loss
Glaucoma
Glasses
Diabetes
Coughed up blood
Tuberculosis
Heart Trouble
High Blood Pressure

Hepatitis or Liver Trouble
Frequent Heartburn
Frequent Diarrhea
Frequent Constipation
Bedwetting
Arthritis
Fatigue
Kidney or Bladder Trouble

Disruptive Sleep
Fever
Chills / Sweats
Sensitivity to Sun
Poison Ivy
Poison Oak
Other:____________________________
____

10. WEIGHT: Weight now:__________ Weight one year ago:___________ Maximum weight: ____________When?_____________________

11. IMMUNIZATIONS: Have you ever experienced any adverse reactions to any immunizations? List dates and reactions, if any.

Tetanus Booster____ Influenza ____

Pneumovax____ MMR ____

HIB____ Prevnar____

12. BIRTH HISTORY: Please complete the following:

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): ____

13. HOSPITALIZATIONS: Please list any surgeries or medical conditions for which you have been hospitalized. (also list dates and doctors)

1. ____
2. ____
3. ____
4. ____
5. ____

14. MARITAL STATUS: ☐ Married ☐ Single ☐ Widowed ☐ Separated ☐ Divorced Number of Children:__________

15. 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: ____

Are you exposed to smoke? ☐ Yes ☐ No Are your symptoms worse at work? If yes please specify:________________________________

Have you missed work because of your allergies? _____________________________ How many days in the last year? ____________________

16. SCHOOL ENVIRONMENT:

What school do you attend? _____________________________________ Is your classroom: ☐ carpeted ☐ tiled

Is there a problem with mold or mildew? ____

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

Do you feel school performance has been affected by allergies? ____

17. FAMILY HISTORY: Do any members of your family have a history of allergy?

	Yes	No	(If Yes): List Relationship
Asthma	☐	☐	
Hay Fever	☐	☐	
Eczema	☐	☐	
Hives	☐	☐	
Swelling	☐	☐	
Pneumonia	☐	☐	
Headaches	☐	☐	
Emphysema	☐	☐	
Lung Disease	☐	☐	

	Yes	No	(If Yes): List Relationship
Cystic Fibrosis	☐	☐	
Tuberculosis	☐	☐	
Thyroid Disease	☐	☐	
Glaucoma	☐	☐	
Diabetes	☐	☐	

Other: Please Specify____________________________________

____

18. ENVIRONMENTAL SURVEY:

Where do you live? ☐City ☐ Rural	Is the home: ☐ carpeted ☐ tiled Is bedroom: ☐ carpeted ☐ tiled
House construction (brick wood etc.):	How old is your ________pillow? _________Mattress?
Approximate age of house:	Is your pillow: ☐ feather ☐ foam rubber ☐ Dacron ☐ encased in plastic ☐ other:
Are any rooms damp or musty?	Is your mattress: ☐ innerspring ☐ foam rubber ☐ Waterbed ☐ encased in plastic ☐ other:
Type of air conditioning? (central, wall unit etc.):	Are your sheets washed in: ☐ cold ☐ warm ☐ hot water
Type of heating? (electric, gas, central, etc.)	Do you have any: ☐ Stuffed furniture ☐ Feather comforters ☐ stuffed animals
Do you have: ☐ Air Cleaner ☐ Air dehumidifier How often do you change/clean your air conditioner and air cleaner filters?	Do you have pets? (List number and kind. dog, cats, birds, horses etc):
Number of indoor plants in the home:	Do your pets spend time indoors?
What kind of grass, shrubs and trees are around the home? List:	Other:

19. SELF EVALUATION:

How would you best describe yourself or child?

Timid	Tense
Quiet	Calm
Forward	Few Friends
Aggressive	Well adjusted
Unfriendly	Spoiled
Introvert	Dependent
Independent	Manipulative
Extroverted	Usually ill
Relaxed	Concerned
Happy	Anxious
Many Friends	Shy

20. SMOKING / ALCHOHOL / CAFFEINE USE:

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 type:____

Average weekly consumption (times per week):____

Do you consume caffeine? ☐Yes ☐ No Any other Drug use? ☐Yes ☐ No If Yes, Explain:_______________________