

Patient's Allergy Survey Sheet

Fax 763-520-2738

Today's date _____

Name _____

DOB _____

Address _____

Occupation _____

Please fill in the blanks and circle other applicable answers.

Please CIRCLE which months have symptoms:

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

Please answer yes or no to the following symptoms:

Sneezing	Yes No	Shortness of breath	Yes No
Watering of the nose	Yes No	Wheezing	Yes No
Blocking of the nose	Yes No	Headaches	Yes No
Itching of the eyes	Yes No	Hives	Yes No
Coughing	Yes No	Dizziness	Yes No
Frequent infections	Yes No	Problems with ears	Yes No

Do you have worse symptoms after exposure to the following?

Hay	Yes No	Eating cheese	Yes No
Barns	Yes No	Eating Mushrooms	Yes No
Raking leaves	Yes No	Drinking beer	Yes No
Mowing Grass	Yes No	Drinking wine	Yes No

List ALL medications you take. (including over-the-counter) _____

What, if any, herbal supplements do you use? _____

Please circle what options apply for your bedroom.

Floor covering:

Carpet with pad
 Carpet without pad
 Rug with pad
 Throw rug
 Linoleum
 None

Mattress Type:

Innerspring
 Polyester filled
 Foam rubber
 Other: _____
 Other mattresses
 in room Yes No

Pillow Type:

Feather
 Polyester filled
 Foam rubber
 Other: _____
 Other pillows in
 room Yes No

Window coverings:

Washable curtains
 Unwashable curtains
 or drapes
 Other: _____

Bed and Bedding:

of beds _____
 Comforter (down)
 Blankets
 Chenille bedspread
 Stuffed toy animals

Walls:

Wallpaper
 Pictures
 Tapestries
 Painted
 Other: _____

Oakdale Ear, Nose & Throat Clinic, P.A. -Allergy Department
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Dust: Does exposure to house dust make your symptoms worse? Yes No
Symptoms _____

Type of house heating system _____

Basement: Circle one. Dry Damp None

What type of work do you do? _____

Are your symptoms worse while at work? _____

Do you or anyone in your household/apartment building use Bounce, Cling Free, or any other dryer type fabric softener? Yes No

List all the foods that have caused an allergic reaction: _____

List favorite, especially enjoyed foods, or craved foods: _____

Danders:

Please circle any of the following pets you have at home, and indicate if they bother you?

Cats	Bothers,	Yes	No
Dogs	Bothers,	Yes	No
Parakeets	Bothers,	Yes	No
Canaries	Bothers,	Yes	No
Horse	Bothers,	Yes	No
Hamster	Bothers,	Yes	No
Rabbits	Bothers,	Yes	No
Gerbils	Bothers,	Yes	No
Other:	Bothers,	Yes	No

Are you exposed to animals in your work? Yes No
If so, what animals? _____

Have you ever reacted **severely** to insect bites such as mosquitoes, gnats, bees, etc?

Yes No If so, which ones? _____
What happened? _____

Do you smoke? Yes No Are you around smokers? Yes No

If we need to contact you, may we leave a message?

Your home phone number with area code: (____) _____ Yes No

Your work phone number with area code: (____) _____ Yes No