

# ALLERGY QUESTIONNAIRE

Patient's Name		Date of Birth
Address		Telephone H W
Date of Appointment	Referring Physician	

**1. 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. Bring this completed form for your first appointment.

Briefly describe the reason for your allergy visit and what you hope to accomplish. \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

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

YES	NO	(Check all items)	Age at Onset	Severity			Comments
				Mild	Mod.	Sev.	
		Asthma (Wheezing)					
		Any Other Breathing Problems					
		Sinus Trouble					
		Hay Fever (Runny, Stuffy, Itchy Nose, Sneezing)					
		Hives or Swelling					
		Eczema or Other Rashes					
		Frequent Infections					
		Food Reactions					
		Drug Reactions					
		Insect Reactions					

**3. SYMPTOMS:** Have you ever had any of the following? If no, leave blank.

	How Many Days in the last month	Severity			Circle the Months Most Severe
		Mild	Mod.	Sev.	
Runny or Stuffy Nose					J F M A M J J A S O N D
Itchy Nose					J F M A M J J A S O N D
Sneezing					J F M A M J J A S O N D
Itchy Eyes					J F M A M J J A S O N D
Wheezing					J F M A M J J A S O N D
Coughing					J F M A M J J A S O N D
Wheezing or Coughing with Exercise					J F M A M J J A S O N D
Skin Problems					J F M A M J J A S O N D

**4. 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 or liquid? If yes, specify below.

Food	Approximate Date	Symptoms	Can food be eaten?		Date food was last eaten.
			Yes	No	

## 5. PRECIPITATING FACTORS/ TRIGGERS:

For each item below, check the appropriate square to indicate whether your (or your child's) condition is affected by the following precipitants/triggers.

	Condition Made Worse	Condition Improved	No Change		Condition Made Worse	Condition Improved	No Change
Cutting or playing in grass, raking leaves	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other strong odors.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High winds, riding in auto	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Specify: _____			
Other outdoor exposure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Exposure to animals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Moldy/mildewed areas or items (basement, attic, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Specify: _____			
Sweeping, dusting or vacuuming	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	"Colds" or viruses	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Smog, smoking or smoke exposure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Physical exertion or exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tobacco Smoke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cold weather	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Air conditioning or heating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other factors: _____			
Cleaning agents, detergents, ammonia, bleach, soap, conditioner, shaving cream, tooth paste, etc. Specify: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Medications:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Paint lacquer, glue, mothballs, Motor fumes, chemicals, fertilizers, insect spray, cooking odors, etc. Specify: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	• Antihistamines or cold preparations			
				• Asthma medications	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				• Nose drops or spray	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				• Aspirin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				• Other _____			

## 6. Residence: List your past residences with your most recent first. Only city and state required.

City & State	# of years	Effect on Symptoms (better, worse, no change)
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____

## 7. PREVIOUS ALLERGY EVALUATION AND THERAPY

Have you every had allergy skin tests?

Yes  No If yes, date \_\_\_\_\_ Physician's Name \_\_\_\_\_

Results of these tests: (If possible, please provide us with a copy)

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Have you ever received allergy injections?

Yes  No If yes, give dates: \_\_\_\_\_

Please list all medications that you are now taking — name, dosage, number of times a day.

Bring all these with you for your first appointment.

\_\_\_\_\_  
 \_\_\_\_\_

Please list all medications you have taken for allergies in the past.

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**8. OTHER MEDICAL PROBLEMS:** Have you ever had any of the following? Answer all items.

Check All Items	Yes	No		Yes	No		Yes	No
Frequent Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Pneumonia, number past year _____	<input type="checkbox"/>	<input type="checkbox"/>	Kidney or Bladder Trouble	<input type="checkbox"/>	<input type="checkbox"/>
Frequent Nosebleeds	<input type="checkbox"/>	<input type="checkbox"/>	Coughed Up Blood	<input type="checkbox"/>	<input type="checkbox"/>	Liver Trouble (e.g. Hepatitis)	<input type="checkbox"/>	<input type="checkbox"/>
Nasal Polyps	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>
Operation on Sinuses	<input type="checkbox"/>	<input type="checkbox"/>	Chest X-Ray	<input type="checkbox"/>	<input type="checkbox"/>	Sexual Problems	<input type="checkbox"/>	<input type="checkbox"/>
Sinus X-Rays	<input type="checkbox"/>	<input type="checkbox"/>	Heart Trouble	<input type="checkbox"/>	<input type="checkbox"/>	Bedwetting	<input type="checkbox"/>	<input type="checkbox"/>
Ear Infections number past year _____	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Poison Ivy or Poison Oak	<input type="checkbox"/>	<input type="checkbox"/>
Hearing Problems	<input type="checkbox"/>	<input type="checkbox"/>	Colic or Spitting up as an Infant	<input type="checkbox"/>	<input type="checkbox"/>	Other _____	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Heartburn	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>
Tonsils/Adenoids Removed (date) _____	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>			

**9. IMMUNIZATIONS:** (List dates and reactions, if any)

Polio _____	Measles _____
DPT _____	Rubella (German Measles) _____
Tetanus Booster _____	Influenza _____
Other (Pneumo-vax) _____	

**10. HOSPITALIZATIONS**

List most recent first	Reason	Date
1. _____		
2. _____		
3. _____		
4. _____		
5. _____		

**11. SURGERY**

List most recent first	Reason	Date
1. _____		
2. _____		
3. _____		
4. _____		
5. _____		

**12. FAMILY HISTORY**

Do any members of your family have a history of allergy?  
 Yes No If yes, list all relatives. (e.g. parents, brothers & sisters, children, aunts, uncles, grandparents, etc.)

Asthma	<input type="checkbox"/>	<input type="checkbox"/>	
Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	
Eczema	<input type="checkbox"/>	<input type="checkbox"/>	
Hives	<input type="checkbox"/>	<input type="checkbox"/>	
Swelling	<input type="checkbox"/>	<input type="checkbox"/>	
Frequent Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	
Other Allergies	<input type="checkbox"/>	<input type="checkbox"/>	

Is there as family history of any other illnesses?			
	Yes	No	If yes, list all relatives
Emphysema or Other Lung Disease			
Cystic Fibrosis			
Tuberculosis			
Thyroid Disease			
Glaucoma			
Diabetes			
Other			

### 13. ENVIRONMENTAL SURVEY

Where do you live? (city or rural)	Number of indoor plants
Age of house _____ years	House construction (brick, wood, etc.)
Are any rooms damp or musty?	Do you have: (a) an air cleaner? (b) an air humidifier?
Type of heating (forced air, steam, spaceheater baseboard, electric, etc.)	Type of air conditioning (central, window, etc.)
<b>Type of Carpet</b> (wood, synthetic, jute) _____ carpet	Bedrooms _____ Living Room _____ Den _____ Dining Room _____
<b>And Pad</b> (rubber, ozite, hair) _____ pad	
How old is your: Pillow? Mattress?	Do you have any: Stuffed furniture? Feather comforters?
Is your pillow: <input type="checkbox"/> feather <input type="checkbox"/> foam rubber <input type="checkbox"/> dacryon <input type="checkbox"/> other _____ <input type="checkbox"/> encased in plastic	Is your mattress: <input type="checkbox"/> foam rubber <input type="checkbox"/> cotton <input type="checkbox"/> innerspring & cotton <input type="checkbox"/> waterbed <input type="checkbox"/> encased in plastic <input type="checkbox"/> other _____
What kinds of grasses, shrubs and trees are in the immediate vicinity of your house?	
Do you have pets? List number and kind (dog, cat, birds, horses, etc.)	Do you pets spend time indoors? <input type="checkbox"/> Yes <input type="checkbox"/> No
What type of work do you do?	
Are you exposed to anything at work that might aggravate your condition? Which things?	
Have you missed any time from work or school because of your allergies? How much time?	
Do you have any other exposures from hobbies, recreational activities, etc.?	

### 14. EDUCATION

Grade School (Highest grade)	High School (1 2 3 4)
College (1 2 3 4)	Other _____

### 15. MARITAL STATUS

<input type="checkbox"/> Married	<input type="checkbox"/> Single	Number of Children _____
<input type="checkbox"/> Widowed	<input type="checkbox"/> Separated	

### 16. EVALUATION

How would you describe yourself (or your child if he/she is being evaluated)? Check those that apply.

<input type="checkbox"/> Timid	<input type="checkbox"/> Concerned
<input type="checkbox"/> Quite	<input type="checkbox"/> Depressed
<input type="checkbox"/> Aggressive	<input type="checkbox"/> Bustling
<input type="checkbox"/> Forward	<input type="checkbox"/> Happy
<input type="checkbox"/> Unfriendly	<input type="checkbox"/> Anxious
<input type="checkbox"/> Introvert	<input type="checkbox"/> Many Friends
<input type="checkbox"/> Tense	<input type="checkbox"/> Shy
<input type="checkbox"/> Calm	<input type="checkbox"/> Relaxed
<input type="checkbox"/> Well Adjusted	<input type="checkbox"/> Independent
<input type="checkbox"/> Few Friends	<input type="checkbox"/> Manipulative
<input type="checkbox"/> Spoiled	<input type="checkbox"/> Extrovert
<input type="checkbox"/> Dependent	<input type="checkbox"/> Usually Ill

### 17. SMOKING/WEIGHT

Have you ever smoked?  Yes  No  
 If yes, how many years? \_\_\_\_\_  
 Do you presently smoke?  Yes  No  
 When did you stop? \_\_\_\_\_  
 Average cigarettes per day at highest point? \_\_\_\_\_  
 If you still smoke, do you think you could stop?  Yes  No  
 Which other family members now smoke?  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 Weight now: \_\_\_\_\_ Weight one year ago: \_\_\_\_\_  
 Maximum weight: \_\_\_\_\_ When? \_\_\_\_\_