taac Topeka Allergy & Asthma Clinic
Excellence • Tradition • Relief

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ALLERGY QUESTIONNAIRE

Today's Date: ______________ **Name:** ______________________________________ **Age:** ______

Gender: _______ **Date of Birth:** ____________ **Occupation:** ______________________________

You were referred by: _____________________ **Primary Care Physician:** ______________________

Reason(s) for visit and when did it begin (year):

1. _______________________________________ 2. _______________________________________

3. _______________________________________ 4. _______________________________________

Have you ever been **tested for allergies?** ☐ No ☐ Yes How? ☐ Skin test ☐ Blood test When?__________

To what was allergy detected? ☐ Dust mite ☐ Molds ☐ Cockroach ☐ Cat ☐ Dog ☐ Trees ☐ Grass ☐ Weeds

Have you ever been treated with **allergy shots?** ☐ No ☐ Yes When and for how long? ______________

Have you ever seen an **Ear, Nose, and Throat doctor**? ☐ No ☐ Yes When? _______________

Have you ever had **nasal or sinus surgery**? ☐ No ☐ Yes When? __________ Doctor? __________

Have you ever taken medications to treat any of the following conditions?

Nasal/ eye allergies or hay fever ☐ No ☐ Yes
Eczema or atopic dermatitis ☐ No ☐ Yes
Asthma or reactive airway disease ☐ No ☐ Yes
Hives or urticaria ☐ No ☐ Yes

What medicines have **improved** your symptoms?

Name	Dose	How often

What medicines have you tried **without improvement**?

Name	Dose	How often

Have you experienced any side effects from any of those medicines? ☐ No ☐ Yes

Medicine	Side-effect	Medicine	Side-Effect

Do you have any nasal symptoms or sinus problems? ☐ No ☐ Yes When did they begin? __________

Runny nose ☐ No ☐ Yes
☐ Watery ☐ Thick ☐ Clear ☐ Colored
Itchy nose ☐ No ☐ Yes
Blocked nose or congestion ☐ No ☐ Yes
Frequent or repetitive sneezing ☐ No ☐ Yes

Sinus pain/ pressure ☐ No ☐ Yes
☐ Cheeks ☐ Forehead ☐ Between eyes
Throat clearing ☐ No ☐ Yes
Nasal or sinus polyps ☐ No ☐ Yes
Loss of smell or taste ☐ No ☐ Yes

Do you have any eye symptoms? ☐ No ☐ Yes

Itchy eyes ☐ No ☐ Yes
Red eyes ☐ No ☐ Yes

Watery eyes or tearing ☐ No ☐ Yes
Irritated eyes ☐ No ☐ Yes

Are nasal symptoms: ☐ All Year ☐ Spring ☐ Summer ☐ Fall ☐ Winter Which is the worst? ________________

Have you been diagnosed with sinus infections requiring antibiotics? ☐ No ☐ Yes

# of infections per year? _______ date of last infection? _________ How treated? _________________________

Have you ever had: ☐ Broken nose ☐ Deviated nasal septum ☐ Tonsils removed ☐ Adenoids removed
☐ Sinus X-ray/ CT?

* * * * *

Have you ever been diagnosed with asthma? ☐ No ☐ Yes When? ________________

Have you ever had:

Persistent cough? ☐ No ☐ Yes

Shortness of breath? ☐ No ☐ Yes
☐ at rest ☐ with exertion

Chest tightness? ☐ No ☐ Yes

Wheezing? ☐ No ☐ Yes
☐ breathing in ☐ breathing out

Have you ever had:

Bronchitis: ☐ No ☐ Yes How many per year? _______
RSV Infection: ☐ No ☐ Yes Age: _______
Chest X- Ray: ☐ No ☐ Yes Date? _________

Pneumonia: ☐ No ☐ Yes How many times? _________
Croup: ☐ No ☐ Yes How many times? _________
Lung function tests: ☐ No ☐ Yes Date? ____________

How often do you experience shortness of breath, wheezing or chest tightness?
☐ Every day ☐ Every other day ☐ Twice a week ☐ Once a week ☐ Twice a month ☐ Once a month

Does shortness of breath or chest tightness **awaken you from sleep**? ☐ No ☐ Yes If yes how often?
☐ Every day ☐ Every other day ☐ Twice a week ☐ Once a week ☐ Twice a month ☐ Once a month

How many puffs of rescue inhaler (albuterol) do you use **per week?** ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ More

Does asthma slow you down or **limit your exercise?** ☐ Never ☐ Rarely ☐ Sometimes ☐ Frequently ☐ Always

What causes your asthma to **worsen**? ____

Does asthma affect the **quality of your life?** ☐ Never ☐ Rarely ☐ Sometimes ☐ Frequently ☐ Always

Have you been **hospitalized for asthma?** ☐ No ☐ Yes How many times? ________
Intensive care unit? ☐ No ☐ Yes

Have you been to an **emergency room** in the **last year for asthma?** ☐ No ☐ Yes How many times?______

Have you taken **prednisone** or other steroids **for asthma?** ☐ No ☐ Yes
How often in the **past 12 months?** ________

Do you have a **peak flow meter?** ☐ No ☐ Yes **Best** peak flow rate: _________

Do you have a spacer device (Aerochamber) for your inhaler? ☐ No ☐ Yes

Which of the following do you feel **causes** or **worsens** your nasal and/ or chest symptoms? (check all that apply)

☐ Seasonal Changes
☐ Outside ☐ In House ☐ Daycare ☐ Farm/Barn
☐ Cats ☐ Dogs ☐ Other Animals
☐ Dust ☐ Grass ☐ Mold/Mildew
☐ Prolonged Talking ☐ Laughter

☐ Cold Air ☐ Heat ☐ Exercise
☐ Colds ☐ Upper Respiratory Infections
☐ Pollution ☐ Fumes ☐ Chemical Odors
☐ Weather Changes ☐High Humidity
☐ Tobacco Smoke

* * * * *

Do you have **eczema** or **atopic dermatitis?** ☐ No ☐ Yes Age of onset_______ Still present? ☐ No ☐ Yes

What causes it to worsen? _____________ What type of moisturizing creams do you use? ___________

Bathing frequency: _____ times per week What type of prescription creams do you use? ____________

Do you have hives? ☐ No ☐ Yes When did they begin? ___________________________

How often? ☐ Daily ☐ A few times per week ☐ Weekly ☐ A few times per month ☐ Monthly ☐ Occasionally

Do you have recurrent **swelling?** ☐ No ☐ Yes **Body part?** ☐ Eyelids ☐ Lips ☐ Face ☐ Limbs ☐ Trunk

Do any of the following symptoms occur in **association with hives or swelling?**

☐ Shortness of Breath ☐ Wheezing ☐ Lightheadedness ☐ Throat Tightness

☐ Difficulty Swallowing ☐ Abdominal Cramps ☐ Vomiting ☐ Diarrhea

Do your hives result in: ☐ Burning ☐ Pain ☐ Bruising ☐ Blood spots

Are hives worsened with: ☐ Vibration ☐ Pressure ☐ Exercise ☐ Heat ☐ Cold ☐ Food ☐ Drugs ☐ Sunlight ☐ Stress ☐ Pets

Do you suspect any causes? ____

Do hives interfere with your ability to **sleep?** ☐ No ☐ Yes

Do hives affect the **quality of your life?** ☐ Never ☐ Rarely ☐ Sometimes ☐ Frequently ☐ Always

Have you taken **prednisone** or other steroids **for hives?** ☐ No ☐ Yes How often in the past year? _______

* * * * *

Do you have any food allergies? ☐ No ☐ Yes

Food	Symptoms of adverse reaction	Date	Treatment	Symptoms on re-exposure

Drug allergies/ Adverse reactions? ☐ No ☐ Yes

Drug	Reaction	Date

Do you have any sensitivity to insect stings? ☐ No ☐ Yes

Insect Type	Symptoms of adverse reaction	Date	Treatment

Do you have latex sensitivity? ☐ No ☐ Yes

* * * * *

Do you have headaches? ☐ No ☐ Yes Which side? ☐ Right ☐ Left ☐ Both

How often? ☐ Daily ☐ 2-3 times per week ☐ A few times a month ☐ Occasionally

How **severe** are your headaches? ☐ Mild ☐ Moderate ☐ Severe ☐ Very severe

Are your headaches **throbbing or pounding?** ☐ No ☐ Yes

Are the headaches **associated** with: ☐ Nausea ☐ Vomiting ☐ Dislike for light ☐ Dislike for sound

Does sleep improve your headache? ☐ No ☐ Yes

Have you ever had any of the following illnesses?

	No	Yes		No	Yes		No	Yes
Hypertension	☐	☐	Emphysema or COPD	☐	☐	Kidney disease	☐	☐
Heart disease	☐	☐	Tuberculosis (Tb)	☐	☐	Osteoporosis	☐	☐
High Cholesterol	☐	☐	HIV	☐	☐	Anemia	☐	☐
Diabetes	☐	☐	Irritable bowel	☐	☐	Rheumatoid arthritis	☐	☐
Thyroid disease	☐	☐	Ear infection	☐	☐	Lupus	☐	☐
Stroke	☐	☐	Reflux or GERD	☐	☐	Degenerative arthritis	☐	☐
Seizure	☐	☐	Glaucoma	☐	☐	Depression	☐	☐
Cancer	☐	☐	Hepatitis	☐	☐	Attention Deficit Disorder	☐	☐

Please list any other health concern: ____

For Children <6 yrs:

Birth History- Full Term: ☐ No ☐ Yes Birth Weight _____________ Breast Fed: ☐ No ☐ Yes
Reactions to formula (type) __________________ Colic/Spitting up as an infant ___________________
Day Care: ☐ No ☐ Yes Since what age? __________ With how many other children? ____________

Please list reason for any hospitalizations or ER visits

Hospitalizations	Year	ER visits	Year
1.		1.	
2.		2.	

Have you had any surgeries? Please list.

Surgery	Year	Surgery	Year
1.		4.	
2.		5.	
3.		6.	

List all medicines that you currently take or attach a list:

Name	Dose	How often	Name	Dose	How often
1.			6.		
2.			7.		
3.			8.		
4.			9.		
5.			10.		

Immunizations

Childhood vaccinations: Up to date? ☐ No ☐ Yes Vaccines not received _______________________

Influenza vaccine: Year _______ Pneumonia vaccine: Year _______ Tetanus vaccine: Year _______

Please list the date of your last: ☐ Mammogram _________ ☐ Echocardiogram _________
☐ Colonoscopy _________ ☐ EKG (heart) _________ ☐ Pap smear _________ ☐ Stress test _________

Review of systems (please check all that apply) :

GENERAL: ☐ Fever ☐ Chills ☐ Night sweats ☐ Weight loss ☐ Fatigue ☐ Loss of appetite

EARS: ☐ Ear pain ☐ Ear pressure ☐ Ear discharge ☐ Hearing loss ☐ Ringing in ear ☐ Popping

EYES: ☐ Eyeglasses ☐ Contact lenses ☐ Glaucoma ☐ Vision change ☐ Dry eyes ☐ Burning

NOSE: ☐ Dryness ☐ Irritation ☐ Bleeding ☐ Deviated Septum ☐ Snoring

MOUTH: ☐ Ulcers ☐ Sore throat ☐ Itching ☐ Gum disease ☐ Bad breath ☐ Sour/bitter taste

THROAT: ☐ Sore throat ☐ Itching ☐ Lump or swelling ☐ Hoarseness

HEART: ☐ Chest pain ☐ Palpitations ☐ Shortness of Breath ☐ Swelling in feet and ankles

LUNGS: ☐ Excessive mucus/phlegm ☐ Coughing up blood ☐ Painful breathing

ABDOMEN: ☐ Cramps ☐ Nausea ☐ Vomiting ☐ Diarrhea ☐ Heartburn

GENITOURINARY: ☐ Frequent urination ☐ Slow urine flow ☐ Blood in urine ☐ Prostate enlargement

HORMONAL: ☐ Excessive thirst ☐ Cold intolerance ☐ Heat intolerance ☐ Menopause

SKIN: ☐ Dry skin ☐ Nail Fungus ☐ Hair loss ☐ Redness ☐ Acne ☐ Rash with metals

MUSCULOSKELETAL: ☐ Joint pain ☐ Joint swelling ☐ Stiffness ☐ Muscle pain ☐ Weakness

NEUROLOGIC: ☐ Dizziness ☐ Numbness ☐ Paralysis ☐ Daytime sleepiness ☐ Insomnia

MENTAL HEALTH: ☐ Poor memory ☐ Confusion ☐ Depression ☐ Anxiety ☐ Panic

Family history (Allergy)	Father	Mother	Brother	Sister	Son	Daughter	Grandfather	Grandmother
Asthma	☐	☐	☐	☐	☐	☐	☐	☐
Hay fever/nasal allergies	☐	☐	☐	☐	☐	☐	☐	☐
Eczema/atopic dermatitis	☐	☐	☐	☐	☐	☐	☐	☐
Hives	☐	☐	☐	☐	☐	☐	☐	☐
Food Allergy	☐	☐	☐	☐	☐	☐	☐	☐
Drug Allergy	☐	☐	☐	☐	☐	☐	☐	☐

Family history (General)	Father	Mother	Brother	Sister	Son	Daughter	Grandfather	Grandmother
Hypertension	☐	☐	☐	☐	☐	☐	☐	☐
Heart disease	☐	☐	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐	☐	☐
Rheumatoid arthritis	☐	☐	☐	☐	☐	☐	☐	☐
Lupus	☐	☐	☐	☐	☐	☐	☐	☐
Celiac	☐	☐	☐	☐	☐	☐	☐	☐
Thyroid disease	☐	☐	☐	☐	☐	☐	☐	☐
Other (please list)	☐	☐	☐	☐	☐	☐	☐	☐

Social History:

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Partner

Drug use: ☐ No ☐ Yes What kind? ______________ Alcohol: ☐ No ☐ Yes Drinks per day? _________

Smoking history: ☐ Current smoker ☐ Former smoker How many years total? ____________

How many packs per day? ________ When did you quit? __________ Attempts to quit? ___________________

Environmental History:

Current home location? ☐ City ☐ Rural ☐ Farm

How old is your: ☐ House?______ ☐ Apartment?______ ☐ Trailer?______ ☐ Dormitory?______

How long there? _________

Heating: ☐ Forced hot air ☐ Hot Water/Radiator ☐ Wood stove ☐ Space heater

Furnace filter: ☐ None ☐ Fiberglass ☐ HEPA ☐ Electrostatic ☐ Other _____________

How often changed/cleaned?___________

Air conditioner: ☐ None ☐ Central ☐ Room unit

Air cleaner: ☐ None ☐ Central ☐ Room Unit Type: ☐ HEPA ☐ Electrostatic

Humidifier: ☐ No ☐ Yes Which room?______ **Dehumidifier:** ☐ No ☐ Yes

Rooms with **carpeting:** ☐ Bedroom ☐ Living room ☐ TV room ☐ Basement

Do you have **dust proof covers?** ☐ No ☐ Yes ☐ On the pillows ☐ On the mattress ☐ On the box spring

Basement: ☐ Finished ☐ Bedroom in basement ☐ Playroom in basement ☐ Previous floods or water leaks

Any visible **mold** in home? ☐ No ☐ Yes Any musty areas? ☐ No ☐ Yes Where?_________________

Pets: Do you have any pets in your home?

☐ Cat number ______ #of years _______ ☐ Indoor ☐ Outdoor ☐ Sleeps in Bedroom ☐ Ever goes in Bedroom

☐ Dog number ______ #of years _______ ☐ Indoor ☐ Outdoor ☐ Sleeps in Bedroom ☐ Ever goes in Bedroom

☐ Horse ☐ Rabbit ☐ Hamster ☐ Guinea Pig ☐ Ferret ☐ Rat ☐ Cow ☐ Other _________

Smokers in the house? ☐ None ☐ Patient ☐ Mother ☐ Father ☐ Spouse/partner ☐ Child ☐ Other

Farm crop exposure: ☐ Milo ☐ Wheat ☐ Corn ☐ Soy ☐ Alfalfa

Do you have any **hobbies?** ☐ No ☐ Yes Please list: ____

Do you believe your occupation causes your symptoms? ☐ No ☐ Yes

Describe**:**____

List all Persons living with the patient and their occupation (student, home worker, attorney, etc.)

Name	Relationship	Age	Occupation

Form filled out by: ____________________________ **Relationship to the patient:**___________________

Thank you for completing the questionnaire!

Physician only: The answers to this questionnaire have been reviewed by:

____ ____________________

Physician Signature Date