



ALLERGY QUESTIONNAIRE

Patient Name:	Account No:
Referring Physician:	
Allergist/Immunologist:	Appointment Date:

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 to your first appointment.**

Briefly describe the reason for your allergy visit and what you hope to accomplish: _____

2. PROBLEMS: Have you ever had any of the following? If not, leave blank.

NASAL/SINUS PROBLEMS	Age of Onset	Severity			Season			
		<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe	<input type="checkbox"/> Winter	<input type="checkbox"/> Spring	<input type="checkbox"/> Summer	<input type="checkbox"/> Fall
Hay fever		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Itchy nose		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Runny nose		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nasal blockage		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Postnasal drip		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Itchy eyes		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Decreased sense of smell		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Facial pain/pressure		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Headache		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Halitosis (bad breath)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dental pain/pressure		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ear pain/pressure		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fever		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sinus infections		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
CHEST PROBLEMS								
Cough		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Wheezing		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of breath		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of breath w/exercise		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other breathing problems		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
SKIN PROBLEMS								
Hives or swelling		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Frequent infections		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drug reaction Specify drug: _____		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Reaction: _____ Date: _____			
Insect reaction Specify insect: _____		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Reaction: _____ Date: _____			
Food reaction Specify food: _____		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Reaction: _____ Date: _____			

3. QUALITY OF LIFE:

How would you rate the overall severity of your symptoms?	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe
How would you rate the impact of your symptoms on your quality of life?	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe

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

Effect on Condition			Effect on Condition		
Cutting or playing in grass, raking leaves	<input type="checkbox"/> Worse	<input type="checkbox"/> None	Strong odors or fumes (Perfumes, diesel, detergents, etc.) Specify: _____ _____	<input type="checkbox"/> Worse	<input type="checkbox"/> None
High winds, riding in auto	<input type="checkbox"/> Worse	<input type="checkbox"/> None			
Cold weather	<input type="checkbox"/> Worse	<input type="checkbox"/> None			
Other outdoor exposure	<input type="checkbox"/> Worse	<input type="checkbox"/> None			
Physical exertion or exercise	<input type="checkbox"/> Worse	<input type="checkbox"/> None	Aspirin	<input type="checkbox"/> Worse	<input type="checkbox"/> None
Sweeping, dusting or vacuuming	<input type="checkbox"/> Worse	<input type="checkbox"/> None	Other medication: Specify: _____ _____ _____ _____ _____ _____	<input type="checkbox"/> Worse	<input type="checkbox"/> None
Air conditioning or heating	<input type="checkbox"/> Worse	<input type="checkbox"/> None			
Moldy/mildewed areas or items (basement, attic, etc.)	<input type="checkbox"/> Worse	<input type="checkbox"/> None			
Smog, smoking or smoke exposure (tobacco, agriculture, etc.)	<input type="checkbox"/> Worse	<input type="checkbox"/> None			
"Colds" or viruses	<input type="checkbox"/> Worse	<input type="checkbox"/> None			
Animals Specify: _____ _____ _____	<input type="checkbox"/> Worse	<input type="checkbox"/> None			
	<input type="checkbox"/> Worse	<input type="checkbox"/> None	Other factors: Specify: _____ _____ _____ _____	<input type="checkbox"/> Worse	<input type="checkbox"/> None
Plants Specify: _____ _____ _____					

5. RESIDENCE: Since onset of symptoms

City & State	Dates	Effect on Symptoms	
1. _____	_____	<input type="checkbox"/> Worse	<input type="checkbox"/> None
2. _____	_____	<input type="checkbox"/> Worse	<input type="checkbox"/> None
3. _____	_____	<input type="checkbox"/> Worse	<input type="checkbox"/> None

6. PREVIOUS ALLERGY EVALUATION AND THERAPY:

<input type="checkbox"/> Yes	<input type="checkbox"/> No	<p>Have you ever had allergy skin tests? If yes, please provide us with a copy of the results.</p> <p>If yes, date(s): _____ Physician name: _____</p> <p>Results of these tests: _____ _____ _____</p>
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<p>Have you ever received allergy injections?</p> <p>If yes, date(s): _____</p> <p>List all medications you've taken for allergies in the past several years: _____ _____ _____</p>
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<p>Are you allergic to any medications? If yes, please list medication and reaction.</p> <p>Medication: _____ Reaction: _____ Date(s): _____</p> <p>Medication: _____ Reaction: _____ Date(s): _____</p> <p>Medication: _____ Reaction: _____ Date(s): _____</p> <p>Medication: _____ Reaction: _____ Date(s): _____</p> <p>Medication: _____ Reaction: _____ Date(s): _____</p>

12. FAMILY HISTORY:

Do any members of your family have a history of allergy?		If yes, list all relatives: (e.g. parents, grandparents, siblings, children, aunts, uncles, etc.)	
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Hay fever	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Eczema	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Hives	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Sinus problem	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Frequent infections	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Other allergies	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Is there a family history of any other illnesses?		If yes, list all relatives: (e.g. parents, grandparents, siblings, children, aunts, uncles, etc.)	
Emphysema or other lung disease	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Cystic fibrosis	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Thyroid disease	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Others	<input type="checkbox"/> Yes <input type="checkbox"/> No		

13. ENVIRONMENTAL SURVEY:

How old is your current home? _____			Do you have a lot of indoor plants?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
How long have you lived in your home? _____			Do you use central heat, woodstove or open fireplace to heat your home?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you live near agricultural activity?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Do you use an air cleaner/purifier?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are any rooms damp or musty? Specify: _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Is your bedroom carpeted?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Has there been a major leak or flooding in your home? Specify location: _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Do you have stuffed furniture in your bedroom?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have pets? Specify type and number: _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Do you use feather comforters?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do your pets spend time indoors?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Does your mattress have an allergy-proof cover? Specify age of mattress: _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do your pets spend time in your bedroom?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Does your pillow have an allergy-proof cover? Specify age of pillow: _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
What type of work do you do?					
Has there been any major leak or flooding in your current workplace? Specify location: _____			<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Are you exposed to anything at work that might aggravate your condition? Specify element: _____			<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Do you have any hobbies that expose you to chemicals, powders or gases? Specify element: _____			<input type="checkbox"/> Yes	<input type="checkbox"/> No	

14. SMOKING:

Have you ever smoked?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Number of years as a smoker: _____
Do you presently smoke?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If you have stopped smoking, when? _____
Does anyone who lives with you smoke?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Specify number smoked per day at highest point: _____

15. PHYSICIAN NOTES:
