ASTHMA & ALLERGY SPECIALISTS

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ALLERGY QUESTIONNAIRE

PATIENT'S NAME	DATE OF BIRTH
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 not, 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
Cutting or playing in grass, raking leaves	☐	☐	☐
High winds, riding in auto	☐	☐	☐
Other outdoor exposure	☐	☐	☐
Moldy/mildewed areas or items (basement, attic, etc.)	☐	☐	☐
Sweeping, dusting or vacuuming	☐	☐	☐
Smog, smoking or smoke exposure	☐	☐	☐
Air conditioning or heating	☐	☐	☐
Cleaning agents, detergents, ammonia, bleach, soap, conditioner, shaving cream, toothpaste, etc. Specify:________	☐	☐	☐
Paint lacquer, glue, mothballs, motor fumes, chemicals, fertilizers, insect spray, cooking odors, etc. Specify:________	☐	☐	☐
Tobacco Smoke	☐	☐	☐

	Condition Made Worse	Condition Improved	No Change
Other strong odors Specify:________	☐	☐	☐
Medications:			
• Antihistamines or cold preparations	☐	☐	☐
• Asthma medications	☐	☐	☐
• Nose drops or spray. How often per day?	☐	☐	☐
• Aspirin	☐	☐	☐
• Other________			
Exposure to animals Specify:________	☐	☐	☐
"Colds" or viruses	☐	☐	☐
Physical exertion or exercise	☐	☐	☐
Cold weather	☐	☐	☐
Other factors________			

6. RESIDENCE:

List your past residences with your most recent first. Only city and state required.

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

7. PREVIOUS ALLERGY EVALUATION AND THERAPY

Have you ever 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
Frequent Headaches	☐	☐
Frequent Nosebleeds	☐	☐
Nasal Polyps	☐	☐
Operation on Sinuses	☐	☐
Sinus X-Rays	☐	☐
Ear Infections number past year ______	☐	☐
Hearing Problems	☐	☐
Glaucoma	☐	☐
Tonsils/Adenoids Removed (date) ______	☐	☐

Check all items	Yes	No
Pneumonia, number past year ______	☐	☐
Coughed Up Blood	☐	☐
Tuberculosis	☐	☐
Chest X-Ray	☐	☐
Heart Trouble	☐	☐
High Blood Pressure	☐	☐
Colic or Spitting Up as an Infant	☐	☐
Frequent Heartburn	☐	☐
Diabetes	☐	☐

Check all items	Yes	No
Kidney or Bladder Trouble	☐	☐
Liver Trouble (e.g., Hepatitis)	☐	☐
Frequent Diarrhea	☐	☐
Sexual Problems	☐	☐
Bedwetting	☐	☐
Poison Ivy or Poison Oak	☐	☐
Other ______ ______	☐	☐

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

Polio ______
DPT ______
Tetanus Booster ______
Measles ______
Rubella (German Measles) ______
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			
Hay Fever			
Eczema			
Hives			
Swelling			
Frequent Pneumonia			
Headaches			
Other Allergies			

Is there a 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 dehumidifier?

Type of heating (forced air, steam, spaceheater baseboard, electric, etc.)

Type of air conditioning (central, window, etc.)

Type of Carpet (wool, synthetic, jute)		Bedrooms	Living Room	Den	Dining Room
	carpet				
And Pad (rubber, ozite, hair)	pad				

How old is your: Pillow?
Mattress?

Do you have any: Stuffed furniture?
Feather comforters?

Is your pillow: ☐ feather ☐ foam rubber ☐ dacron ☐ other ______ ☐ encased in plastic

Is your mattress: ☐ foam rubber ☐ cotton ☐ innerspring & cotton ☐ waterbed ☐ encased in plastic ☐ 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 your pets spend time indoors? ☐ Yes ☐ 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

☐ Married ☐ Single
☐ Widowed ☐ Separated Number of Children______

16. EVALUATION

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

☐ Timid	☐ Concerned
☐ Quiet	☐ Depressed
☐ Aggressive	☐ Bustling
☐ Forward	☐ Happy
☐ Unfriendly	☐ Anxious
☐ Introvert	☐ Many Friends
☐ Tense	☐ Shy
☐ Calm	☐ Relaxed
☐ Well Adjusted	☐ Independent
☐ Few Friends	☐ Manipulative
☐ Spoiled	☐ Extrovert
☐ Dependent	☐ 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?______

BRING THIS COMPLETED FORM WITH YOU FOR YOUR FIRST APPOINTMENT. THANK YOU.