ALLERGY CLINIC-PATIENT QUESTIONNAIRE

NAME:____DOB:__________TODAY'S DATE: ___________

A. Please check any of the following problems which you have had, and record when they started:

Problem/Date of Onset

- ☐ sniffles
- ☐ nasal congestion
- ☐ sneezing
- ☐ runny nose
- ☐ nose bleeds
- ☐ sore throat
- ☐ mouth breathing
- ☐ snoring
- ☐ itchy eyes
- ☐ red eyes
- ☐ watery eyes
- ☐ itchy mouth or ears
- ☐ diarrhea
- ☐ bloating
- ☐ gas
- ☐ formula problem
- ☐ colic
- ☐ other (please name)

Problem/Date of Onset

- ☐ chronic cough
- ☐ recurrent cough
- ☐ wheezing
- ☐ recurrent colds
- ☐ otitis media (middle ear infection)
- ☐ bronchitis
- ☐ headache
- ☐ migraine
- ☐ hives
- ☐ eczema
- ☐ dry skin
- ☐ itchy skin
- ☐ draggy feeling
- ☐ hyperactivity
- ☐ behavior prob
- ☐ poor appetite

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B. Have you noticed that symptoms come on:

At any special time of day or night? Yes ☐ No ☐
If yes, when?

At all times of the year? Yes ☐ No ☐
If yes, which months are worse?

Only at a particular time of the year? Yes ☐ No ☐
When?

In any particular room of the house? Yes ☐ No ☐
Which one?

At work/At school? Yes ☐ No ☐
If yes, are there materials, dusts, or fumes which bring on or increase your symptoms?

What symptoms are present almost daily?

C. Please check which of the following make your symptoms worse.

- ☐ dusting house
- ☐ flowers
- ☐ vacuuming
- ☐ raking leaves
- ☐ trees
- ☐ basement
- ☐ tobacco smoke/wood smoke
- ☐ grass
- ☐ exercise
- ☐ aspirin
- ☐ other medication (which?)
- ☐ foods (which?)
- ☐ others (please name)

NAME:____DOB:__________TODAY'S DATE: __________

D. Pollen Allergies:

- ☐ aggravated outdoors
- ☐ aggravated on windy days
- ☐ improved in air-conditioning

E. Mold Allergies:

- ☐ worse in damp places
- ☐ worse when mowing or playing on grass
- ☐ caused by raking leaves

F. Dust/Mite/Animal/Mold Allergies:

- ☐ aggravated indoors
- ☐ worse 30 min after going to bed
- ☐ worse in the winter
- ☐ nasal symptoms with little eye involvement
- ☐ bothered by central air conditioning

G. Previous treatment:

Have you inquired about allergy treatment in the past? Yes ☐ No ☐

Have you ever been treated for allergy in the past? Yes ☐ No ☐

Have you ever received occasional "allergy shots" or steroids for hayfever? Yes ☐ No ☐

Have you received desensitizing treatment? Yes ☐ No ☐

Have you taken antihistamines? Yes ☐ No ☐
Please name them all (including over the counter brands).

NAME:____DOB:__________TODAY'S DATE: __________

Have you used nasal sprays or eye drops for allergy? Yes ☐ No ☐
Please name them.

Have you ever used asthma medications, such as inhalers/ breathing machines? Yes ☐ No ☐
If yes, please name the medication used.

What soap do you use when bathing?

What detergent/fabric softener do you use?

If you have eczema, what medications have you tried?

H. Medications:
Do you ever take aspirin or ibuprofen or acetaminophen? Yes ☐ No ☐
If so, how frequently?

I. Hospitalizations:
Have you ever been admitted to the hospital for any reason? Yes ☐ No ☐
If yes, please record how times and why:

J. Family History:
Do (or did) any of your family members receive treatment for allergy? Yes ☐ No ☐

Do they now or did they in the past suffer from any of the symptoms mentioned at the beginning of this

history form? Yes ☐ No ☐
If yes, please record the symptoms by the appropriate person.
Mother:

Father:

Brother:

Sister:

NAME:_______________________________________DOB:_________TODAY'S DATE: __________

J. Family History Continued:
Grandparent:

Grandparent:

K. Do you own your own home? Yes ☐ No ☐

How old is your home?

Is there mildew in your home? Yes ☐ No ☐

Construction of home: Frame _☐ Brick _☐ Block _☐ Other

Type of heating

Central Air? Yes ☐ No ☐

Do you have a humidifier? Yes ☐ No ☐

Attic fan? Yes ☐ No ☐

What kind of floor covering?

Do you have a basement? Yes ☐ No ☐
If yes, how is it used?

Do you sleep in the basement? Yes ☐ No ☐

Does anyone in your family smoke? Yes ☐ No ☐
If yes, who?

Is there any smoking in your home or car? Yes ☐ No ☐

Do you use/own any product filled with feathers or down? Yes ☐ No ☐

Pillow_☐ Coat_☐ Vest_☐ Comforter_☐

Thank you for your patience, please continue……

NAME:____DOB:_________TODAY'S DATE: __________

K. Continued

Do you have pets in your home (including fish)? Yes ☐ No ☐

Please list:

Are you exposed to any other animals? Yes ☐ No ☐

Animals in the classroom? Yes ☐ No ☐

Do you own or ride horses? Yes ☐ No ☐

Do you want to be tested for any animal other than dog and cat? Yes ☐ No ☐

Guinea pig_☐ Rabbit_☐ Cattle_☐ Goat_☐ Horse_☐ Birds_☐

Other

Do you attend a basement schoolroom? Yes ☐ No ☐

L. Expectations:

Please describe what you hope to achieve during this office visit:

List three (3) questions you would most like to have answered:

1.

2.

3.

Use this space to record any other relevant (or possibly relevant) information, **including a list of all current medications and dosage:**

Thank you for your patience, please continue……

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FOOD ALLERGY – NUTRITIONAL QUESTIONNAIR
PLEASE READ EACH QUESTION CAREFULLY.
THEN CHECK YES OR NO TO INDICATE YOUR ANSWER. IF YES, PLEASE EXPLAIN.

Yes☐ **No**☐ 1. Are there any foods or beverages that you a) crave or b) eat frequently? List

a) b)

Yes☐ **No**☐ 2. Are there any foods or beverages that you dislike? List example.

Yes☐ **No**☐ 3. Do you eat snacks frequently between meals? List examples.

Yes☐ **No**☐ 4. Did you have any problems with food when you were a child? Please describe:

Yes☐ **No**☐ 5. Do you have problems with any foods now? Name them:

Yes☐ **No**☐ 6. Were you breastfed, or what formula were you given?

Yes☐ **No**☐ 7. Do you experience belching, abdominal distention, bloating or cramps following meals?

Yes☐ **No**☐ 8. Are you awakened between the hours of 1:00 AM and 5:00 AM with the following symptoms?

Headache☐ Dizziness☐ Stomach cramps☐ Bloating☐
Dry cough☐

Yes☐ **No**☐ 9. Do you or any member of your family have:

Hayfever☐ Asthma☐ Hives☐ Chronic skin condition☐

Migraines☐ Headaches☐ Colitis☐

NAME:_____________________________________**DOB:**_________**TODAY'S DATE:** __________

Yes_☐ **No**_☐ **10.** During childhood did you have any of the following:

Eczema_☐ Hayfever_☐ Asthma_☐ Food feeding problems_☐

Yes_☐ **No**_☐ 11. Do you have itching of the:

Skin_☐ Palate_☐ Roof of your mouth_☐ Skin rash_☐

Yes_☐ **No**_☐ 12. Do you frequently notice swelling of your

Ankles_☐ Feet_☐ Hands_☐ Face_☐

Yes_☐ **No**_☐ 13. Do you have marked fatigue two or three hours after meals?

Yes_☐ **No**_☐ 14. Do you have excessive chilling when a sudden change in temperature occurs?

Yes_☐ **No**_☐ 15. Do you have frequent headaches or "Migraines"?

Yes_☐ **No**_☐ 16. Do you have alternating constipation or diarrhea?

Yes_☐ **No**_☐ 17. Do you have joint or muscle pain or stiffness?

Yes_☐ **No**_☐ 18. Do you have fluctuating vision?

Yes_☐ **No**_☐ 19. Do you have recurring fungal infections?

Vaginitis_☐ Athlete's foot_☐ Jock itch_☐ Ring worm_☐