PREMIER MEDICAL
ASSOCIATES

ALLERGY HISTORY QUESTIONNAIRE

(To be filled out by the patient)

Check (3) the box if the answer is yes. Leave blank if the answer is no. Answer each question as accurately as possible.

For questions 1-39, give major symptoms 2 checks and lessor symptoms 1 check.

A ALLERGY SYMPTOMS

Do you have any of the following symptoms?

EAR, NOSE, AND THROAT

1. ☐ ☐ Sneezing and/or nasal itchiness?
2. ☐ ☐ Watery nasal drainage?
3. ☐ ☐ Nasal congestion, blockage, and stuffiness?
4. ☐ ☐ Post nasal drip?
5. ☐ ☐ Thick, cloudy mucus discharge?
6. ☐ ☐ Frequent “sinus” problems and/or infections?
7. ☐ ☐ Frequent colds?
8. ☐ ☐ Loss of smell?
9. ☐ ☐ Recurrent sore throats?
10. ☐ ☐ Itching of mouth, throat and/or palate?
11. ☐ ☐ Swelling of tongue, lips and/or palate?
12. ☐ ☐ Recurrent hoarseness and/or laryngitis?
13. ☐ ☐ Recurrent ear infections?
14. ☐ ☐ Popping or fullness in the ears?
15. ☐ ☐ Hearing loss?
16. ☐ ☐ Itching ears?

EYES

17. ☐ ☐ Eye itchiness, watering, redness?
18. ☐ ☐ Swelling or puffiness around the eyes?

CHEST

19. ☐ ☐ Chronic dry cough?
20. ☐ ☐ Chest tightness, congestion and/or shortness of breath?
21. ☐ ☐ Asthma (wheezing)?
22. ☐ ☐ Asthma present only with exercise?
23. ☐ ☐ Frequent pneumonia and/or bronchitis?

SKIN / JOINTS

24. ☐ ☐ Eczema?
25. ☐ ☐ Hives / urticaria?
26. ☐ ☐ Allergic skin reaction (swelling)?
27. ☐ ☐ Itchiness?
28. ☐ ☐ Muscle or joint pain and/or swelling?

GASTRO-INTESTINAL

29. ☐ ☐ Indigestion, belching, gas, heartburn?
30. ☐ ☐ Bloating?
31. ☐ ☐ Diarrhea?
32. ☐ ☐ Constipation?
33. ☐ ☐ Nausea and/or vomiting?

GENERAL

34. ☐ ☐ Dizziness, unsteadiness, or light-headedness?
35. ☐ ☐ Chronic headaches / migraines?
36. ☐ ☐ Depression, anxiety or tension?
37. ☐ ☐ Chronic fatigue or tiredness?
38. ☐ ☐ Difficulty concentrating?
39. ☐ ☐ Hyperactivity?

B MAJOR SYMPTOM HISTORY

Initial Onset

When did symptoms first start?

40. ☐ In infancy (0-2 yrs.)?
41. ☐ In childhood (2-12 yrs.)?
42. ☐ As a young adult (12-20 yrs.)?
43. ☐ Between 20-40 years of age?
44. ☐ Over 40 years of age?

Recent Onset

How long ago did symptoms most recently begin?

45. ☐ days?
46. ☐ weeks?
47. ☐ months?
48. ☐ more than one year?

Pattern

49. ☐ Do symptoms begin suddenly?
50. ☐ Do symptoms disappear suddenly?

Duration of Symptoms

How long do symptoms last?

51. ☐ day(s):
52. ☐ weeks?
53. ☐ months?
54. ☐ varying periods?

C SEASONAL INCIDENCE

Duration

55. ☐ Are symptoms constant all year round?

Seasonal

If symptoms are constant year round, do they get worse in:

56. ☐ Spring?
57. ☐ Summer?
58. ☐ Fall?
59. ☐ Winter?

If symptoms are not constant year round, do they occur only in:

60. ☐ Spring?
61. ☐ Summer?
62. ☐ Fall?
63. ☐ Winter?

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C SEASONAL INCIDENCE (Continued)

Months?
If symptoms are not constant, in which months do they occur or worsen:

64. ☐ January?
65. ☐ February?
66. ☐ March?
67. ☐ April?
68. ☐ May?
69. ☐ June?
70. ☐ July?
71. ☐ August?
72. ☐ September?
73. ☐ October?
74. ☐ November?
75. ☐ December?

D ENVIRONMENTAL INCIDENCE

Symptoms
Weather

76. ☐ In wet, damp weather?
77. ☐ In cold, cool weather?
78. ☐ In windy weather?
79. ☐ In changing weather?
80. ☐ In dry weather?
81. ☐ In hot weather?

Time of Day

82. ☐ In the morning on arising?
83. ☐ In the late morning?
84. ☐ In the evening?
85. ☐ After going to bed?

Location

86. ☐ Outdoors?
87. ☐ Indoors?
88. ☐ When mowing the lawn?
89. ☐ In grassy areas (parks or lawn)?
90. ☐ In fields and/or barns?
91. ☐ When raking leaves?
92. ☐ In dusty areas?
93. ☐ In the bedroom?
94. ☐ In damp, moldy, mildewy areas (eg. basements?)
95. ☐ At home?
96. ☐ At work or school?
97. ☐ At sea level?
98. ☐ At high elevations?
99. ☐ In air conditioning?
100. ☐ In forced air heating?

Exposures I

101. ☐ Around animals?
102. ☐ When vacuuming or cleaning?
103. ☐ While exercising?
104. ☐ After eating?
105. ☐ After drinking alcohol?
106. ☐ Around chemicals?
107. ☐ Around soaps and detergents?
108. ☐ Around tobacco smoke?
109. ☐ Around cosmetics and perfumes?
110. ☐ Around paints and/or cleaners?
111. ☐ Around gasoline fumes or exhaust?

Exposures II
Symptoms improve:

112. ☐ Indoors?
113. ☐ Outdoors?
114. ☐ In air conditioning?
115. ☐ After taking antihistamines?
116. ☐ In hot, dry weather?
117. ☐ In cold, damp, rainy weather?

E ENVIRONMENTAL CONDITIONS

Home/Work Environment
To which of the following are you often exposed?

118. ☐ Air conditioning?
119. ☐ Forced air heating?
120. ☐ Thick carpeting and/or heavy drapes?
121. ☐ Down/feather pillows, woolen blankets, or comforters?
122. ☐ Cigarette smoke?
123. ☐ Mold or mildew?
124. ☐ Dust?
125. ☐ Dog(s)?
126. ☐ Cat(s)?
127. ☐ Other animals?
128. ☐ Birds?
129. ☐ House plants?

Other Frequent Environmental Exposures

130. ☐ Cosmetics (perfumes, talc, soap power or detergent)?
131. ☐ Chemicals (house sprays, insecticides, paint, varnish)?
132. ☐ Grass (parks or lawns)?
133. ☐ Dust?
134. ☐ Mold / Mildew?
135. ☐ Animals?
136. ☐ Paper or newsprint?

F KNOWN ALLERGIES

137. ☐ Dogs?
138. ☐ Cats?
139. ☐ Other pets?
140. ☐ Guinea pigs / mice?
141. ☐ Hamsters / rabbits?
142. ☐ Horses / cattle?
143. ☐ Birds?
144. ☐ Tree pollen?
145. ☐ Grass pollen?
146. ☐ Weed pollen?
147. ☐ House dust and/or dust mites?
148. ☐ Mold, mildew, or fungus?
149. ☐ Feathers or down?
150. ☐ Foods?
151. ☐ Insect bites or stings?
152. ☐ Chemicals (eg. paint fumes)?
153. ☐ Perfumes or cosmetics?
154. ☐ Soaps and detergents?

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G FAMILY HISTORY

Members of your family with allergies:
155. ☐ One parent?
156. ☐ Both parents?
157. ☐ Brothers and/or sisters?
158. ☐ Other blood relatives?

H CHILDHOOD HISTORY

In childhood, did you have:
159. ☐ Nasal (hayfever) or sinus problems?
160. ☐ Recurrent ear infections?
161. ☐ Frequent colds and/or sore throats?
162. ☐ Asthma or bronchitis?
163. ☐ Stomach problems (colic)?
164. ☐ Skin problems (eczyma, hives)?

I PAST HISTORY

165. ☐ Have you previously had allergy immunotherapy (shots)?
166. ☐ Did your immunotherapy last for more than one year?
167. ☐ Did your symptoms improve on immunotherapy?
168. ☐ Did you ever have reactions from previous shots?
169. ☐ Have you had nasal polyps?
170. ☐ Have you had any nasal or sinus surgery?
171. ☐ Have you ever had ear tubes put in?

J MEDICATIONS

Are you now taking any of the following?
172. ☐ Antihistamines and/or decongestants?
173. ☐ Cortisone?
174. ☐ Asthma medications (pills or inhalers)?
175. ☐ Over the counter nasal sprays?
176. ☐ Prescription nasal sprays (cortisone, cromolyn, etc.)?
177. ☐ Aspirin or anti-inflammatory drugs?
178. ☐ Birth control pills?
179. ☐ Blood pressure pills?
180. ☐ Beta blockers (Inderal)?
181. ☐ Antibiotics?

Are you allergic to:
182. ☐ Antibiotics?
183. ☐ Aspirin and/or arthritis medication?
184. ☐ Pain medication?

K MEDICAL HISTORY

Do you suffer from:
185. ☐ Thyroid problems?
186. ☐ Diabetes?
187. ☐ High blood pressure?
188. ☐ Stomach ulcers, hernia, etc.
189. ☐ Have you ever been diagnosed as having colitis?

L GENERAL

Do your symptoms affect daily life:
190. ☐ Slightly?
191. ☐ Moderately?
192. ☐ Severely?
193. ☐ Are you a smoker?
194. ☐ If so, more than one pack per day?
195. ☐ Have you smoked in the past two years?
196. ☐ Are you presently under any unusual stress?
197. ☐ Have you recently changed your work or home environment?
198. ☐ If so, were your symptoms worsened?

M FOOD SPECIFIC SYMPTOMS

Are your symptoms brought on or worsened:
199. ☐ After eating?
200. ☐ After drinking alcohol?
201. ☐ After eating foods with preservatives and/or additives?
202. ☐ Do you feel tightness in your chest after eating?
203. ☐ Does your tongue or palate swell or itch after eating?
204. ☐ Do you feel uncomfortable or sick if you skip a meal?
205. ☐ Do you feel lethargic and/or drowsy after eating?
206. ☐ Do your symptoms decrease if your skip a meal?
207. ☐ Do you have any specific food cravings?

Foods Frequently Eaten (At Least Once Daily):
208. ☐ Dairy products
209. ☐ Wheat
210. ☐ Chocolate
211. ☐ Peanuts
212. ☐ Alcohol
213. ☐ Eggs
214. ☐ Corn
215. ☐ Orange
216. ☐ Tomato
217. ☐ Yeast
218. ☐ Pork
219. ☐ Soybean

Foods To Which You Have Reacted:
220. ☐ Dairy products
221. ☐ Wheat
222. ☐ Chocolate
223. ☐ Peanuts
224. ☐ Alcohol
225. ☐ Eggs
226. ☐ Corn
227. ☐ Orange
228. ☐ Tomato
229. ☐ Yeast
230. ☐ Pork
231. ☐ Soybean

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PATIENT MASTER INFORMATION

Patient's Name ______________________ Patient's # ______________

Occupation ______________________ Date of Birth ______________

Address ______________________________________

____

____

Phone: Residence (   ) ______________ Business (   ) ______________

Occupation ______________________________________

Animals kept by patient: ☐ None ☐ Cat ☐ Dog ☐ Other ______________

Medications taken other than those already mentioned ______________

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Patient Notes: ______________________________________