ALLERGY QUESTIONNAIRE

Patient's Name: ____________________________________**Date:**_____________

Please fill in the blanks and check the other applicable answers, feel free to make any additional comments. Base your answers on your own observations and not on what you have been told by others or what you may know about previous skin tests. Though these questions are rather detailed, the information provided will be of major assistance in helping you. If any question is not clear, leave the answer blank and put a check mark in the left hand margin. All information will be considered confidential.

DO NOT TAKE. ANY HAY FEVER OR ASTHMA MEDICATION FOR 4 DAYS PRIOR TO YOUR VISIT TO THE OFFICE, unless you are taking steroids (cortisone), fluticasone (Flovent or Advair) which may be continued. However, if you are too ill to stop your medications, please continue to take them.

SYMPTOMS

(Do you have any of the following? If so, please check. Place approximate onset by month and year, if known, beside each or the symptoms you check).

Eyes
- ☐ Itching
- ☐ Burning
- ☐ Tearing
- ☐ Swelling
- ☐ Redness
- ☐ Discharge

Nose
- ☐ Itching
- ☐ Runny
- ☐ Stuffy
- ☐ Sneezing
- ☐ Loss of Smell
- ☐ Discharge

Ears
- ☐ Itching
- ☐ Fullness
- ☐ Popping
- ☐ Drainage
- ☐ Frequent Infections

Throat
- ☐ Itching
- ☐ Postnasal Drip
- ☐ Mucus in Morning

Chest
- ☐ Wheezing
- ☐ Tightness
- ☐ Coughing
- ☐ Shortness of Breath
- ☐ Pain

Skin
- ☐ Hives
- ☐ Eczema

Check months when symptoms present:

- ☐ All Year
- ☐ January
- ☐ February
- ☐ March
- ☐ April
- ☐ May
- ☐ June
- ☐ July
- ☐ August
- ☐ September
- ☐ October
- ☐ November
- ☐ December

INHALANTS

Dust

Does Exposure to house dust make your symptoms worse? ☐ Yes ☐ No

What are the symptoms? ____

Are you symptoms worse during winter? ☐Yes ☐ No

Environmental Survey

Are you symptoms worse in certain areas of your house? ☐ Yes ☐ No

If so, where? ____

Type of Home ____

Age of House ____________years Occupied _________years

Is your house located near a (please check)

☐ Field ☐Forest ☐Lake ☐River ☐Farm

Type of heating system:

☐Forced air - gas or oil
☐Hot water
☐Steam
☐Space heater

Do you have:

Humidifier ☐ Yes ☐No
Air conditioning ☐ Yes ☐No
Electronic air cleaner ☐ Yes ☐No

Your Bedroom:

Rug Type

☐Shag
☐Short Pile
☐Throw
☐None

Mattress Type

☐IFoam Rubber
☐Feather
☐Cotton
Age________

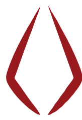
Pillow Type

☐IFoam Rubber
☐Feather
☐Dracon
Age________

Basement:

☐None
☐Dry
☐Damp
☐Finished
☐Unfinished

Musty Smell? ☐ Yes ☐No
Is there a dehumidifier ☐ Yes ☐No



MOLDS:

Are your symptoms worse after exposure to the following?

Hay	☐ Yes	☐ No
Barns	☐ Yes	☐ No
Damp Basements	☐ Yes	☐ No
Cutting Grass	☐ Yes	☐ No
Raking Leaves	☐ Yes	☐ No

DANDERS:

Do you have animals in your home? ☐ Yes ☐ No If so, what type? ____________________

Do you have symptoms from any animals? ☐ Yes ☐ No

If yes, what animals and what symptoms? ____________________

MISCELLANEOUS

Do you have symptoms after exposure to the following?

Cosmetics	☐ Yes	☐ No	Insecticides	☐ Yes	☐ No
Perfumes	☐ Yes	☐ No	Paint & Varnish	☐ Yes	☐ No
Hair Sprays	☐ Yes	☐ No	Soaps & Detergents	☐ Yes	☐ No
Chemicals	☐ Yes	☐ No	Wool	☐ Yes	☐ No
Newspaper	☐ Yes	☐ No	Cooking Odors	☐ Yes	☐ No
Aerosols	☐ Yes	☐ No	Others Smoking	☐ Yes	☐ No

PHYSICAL AGENTS

Are your symptoms affected by the following?

Heat	**Drafts**	**Exercise**	**Cold**
☐ Worse	☐ Worse	☐ Worse	☐ Worse
☐ Better	☐ Better	☐ Better	☐ Better
☐ No Change	☐ No Change	☐ No Change	☐ No Change

Temperature Change	**Increased Humidity**	**Air Conditioning**	**Weather Changes**
☐ Worse	☐ Worse	☐ Worse	☐ Worse
☐ Better	☐ Better	☐ Better	☐ Better
☐ No Change	☐ No Change	☐ No Change	☐ No Change

Any flare of symptoms with upper respiratory infections (colds)? ☐ Yes ☐ No

Are your symptoms worse at work? ☐ Yes ☐ No

Specific Job: ____________________

Do you have any hobbies? ☐ Yes ☐ No

If so, list: ____________________

Are your symptoms better away from home (vacations, etc.)? ☐ Yes ☐ No

Are your symptoms worse away from home (vacations, etc.)? ☐ Yes ☐ No

FOODS

Do any foods make you worse? ☐Yes ☐No
If so, which ones, and what symptoms are produced? ____________________

Have any special allergy diets been tried in the past? ☐Yes ☐No
Type of diet and conclusions reached? ____________________

Do you have symptoms from eating:
☐Cheese ☐Mushrooms ☐Beer ☐Wine

Do you have symptoms from eating melons? ☐Yes ☐No

Rashes from contactants:

Poison Ivy	☐Yes	☐No	Clothing	☐Yes	☐No
Poison Sumac	☐Yes	☐No	Metals	☐Yes	☐No
Poison Oak	☐Yes	☐No	Hobbies	☐Yes	☐No
Other Plants	☐Yes	☐No	Household Agents	☐Yes	☐No
Work	☐Yes	☐No	Adhesive Tapes	☐Yes	☐No
Ointments	☐Yes	☐No	Soap	☐Yes	☐No
Cosmetics	☐Yes	☐No	Latex	☐Yes	☐No

Have you ever had Hives? ☐ Yes ☐ No
If so, what was the cause, if known? ____________________

Have you ever had any reactions to medications? ☐Yes ☐No
If yes, please list medications and type of reaction ____________________

Have you ever had any reactions to insect stings or bites? ☐ Yes ☐No
If yes, what insect and type of reaction ____________________

IMMUNIZATIONS:

Please check appropriate answer and also check off if you were immunized in past year?

			Within the last year?	
DPT	☐Received	☐ Adverse Reaction	☐ Yes	☐No
Polio	☐Received	☐ Adverse Reaction	☐ Yes	☐No
Small Pox	☐Received	☐ Adverse Reaction	☐ Yes	☐No
Measles	☐Received	☐ Adverse Reaction	☐ Yes	☐No
Influenza (Flu)	☐Received	☐ Adverse Reaction	☐ Yes	☐No
Mumps	☐Received	☐ Adverse Reaction	☐ Yes	☐No
Tetanus	☐Received	☐ Adverse Reaction	☐ Yes	☐No
Horse Serum	☐Received	☐ Adverse Reaction	☐ Yes	☐No
Blood Transfusions	☐Received	☐ Adverse Reaction	☐ Yes	☐No
Gamma Globulin	☐Received	☐ Adverse Reaction	☐ Yes	☐No

HABITS:

Average hours of sleep per night ________

Smoker/ Non-Smoker Packs per day ________Cigars per day ________years smoking __________

Drink/ Do not drink Bottles of beer per week _______ Glasses of wine per week___________

Other alcoholic beverages per week _________________

SYSTEM REVIEW:

Do you now, or have you had:

General

- Fatigue ☐ Yes ☐ No
- Chills ☐ Yes ☐ No
- Fever ☐ Yes ☐ No
- Dizziness ☐ Yes ☐ No
- Fainting ☐ Yes ☐ No
- Sweats ☐ Yes ☐ No

Eyes

- Blurred vision ☐ Yes ☐ No
- Double vision ☐ Yes ☐ No
- Spot before eyes ☐ Yes ☐ No
- Pain behind eyes ☐ Yes ☐ No
- Infected eyes ☐ Yes ☐ No
- Any change in vision ☐ Yes ☐ No
- Glasses last checked___________ ☐ Yes ☐ No

Nose

- Frequent Colds ☐ Yes ☐ No
- Mouth Breathing ☐ Yes ☐ No
- Recurrent Sinuses ☐ Yes ☐ No
- Loss of smell ☐ Yes ☐ No

Chest

- Coughing up blood ☐ Yes ☐ No
- Recurrent pneumonia ☐ Yes ☐ No
- Night sweats ☐ Yes ☐ No

Shortness of Breath when…

- Walking several blocks ☐ Yes ☐ No
- Walking one flight of stairs ☐ Yes ☐ No
- Lying down ☐ Yes ☐ No
- Aware of heart beating ☐ Yes ☐ No

Head

- Frequent or severe aches ☐ Yes ☐ No
- Acne ☐ Yes ☐ No
- Patchy ☐ Yes ☐ No

Ears

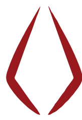
- Pain ☐ Yes ☐ No
- Hearing difficulty ☐ Yes ☐ No
- Hearing loss ☐ Yes ☐ No
- Ringing ☐ Yes ☐ No
- Recurrent infections ☐ Yes ☐ No

Throat

- Frequently sore ☐ Yes ☐ No
- Voice Change ☐ Yes ☐ No
- Difficulty swallowing ☐ Yes ☐ No
- Frequent infections ☐ Yes ☐ No

Bones & Joints

- Swelling ☐ Yes ☐ No
- Deformity ☐ Yes ☐ No
- Arthritis ☐ Yes ☐ No
- Varicose veins ☐ Yes ☐ No
- Phlebitis ☐ Yes ☐ No
- Neuritis ☐ Yes ☐ No
- Swelling of feet ☐ Yes ☐ No



SYSTEM REVIEW (CONT.):

Gastrointenstinal

Appetite: ☐Excessive ☐Good ☐Fair ☐Poor

Weight: ☐ Gain ☐ Loss How much? _______

Nausea ☐ Yes ☐ No

Blood in vomitus ☐ Yes ☐ No

Vomiting ☐ Yes ☐ No

Recurrent belching ☐ Yes ☐ No

Diarrhea ☐ Yes ☐ No

Recurrent abdominal pain ☐ Yes ☐ No

Constipation ☐ Yes ☐ No

Fatty stool ☐ Yes ☐ No

Blood in Stool ☐ Yes ☐ No

Worms ☐ Yes ☐ No

Genito-Urinary

Difficult passing urine ☐ Yes ☐ No

Pain on passing urine ☐ Yes ☐ No

Frequently passing urine ☐ Yes ☐ No

Inability to hold urine ☐ Yes ☐ No

Blood urine ☐ Yes ☐ No

Parents had:

WHO?________________________ WHO?________________________

Anemia ☐ Yes ☐ No

Asthma ☐ Yes ☐ No

Cancer ☐ Yes ☐ No

Diabetes (sugar) ☐ Yes ☐ No

Epilepsy ☐ Yes ☐ No

Glaucoma ☐ Yes ☐ No

Gout ☐ Yes ☐ No

Hay fever or other nasal allergy ☐ Yes ☐ No

Heart Trouble ☐ Yes ☐ No

High Blood Pressure ☐ Yes ☐ No

Hives ☐ Yes ☐ No

Immune Deficiency ☐ Yes ☐ No

Kidney or Bladder trouble ☐ Yes ☐ No

Migraine ☐ Yes ☐ No

Mononucleosis ☐ Yes ☐ No

Nervous breakdown ☐ Yes ☐ No

Pulmonary Embolism ☐ Yes ☐ No

Seizures ☐ Yes ☐ No

Stroke ☐ Yes ☐ No

Thyroid problem ☐ Yes ☐ No

Tuberculosis ☐ Yes ☐ No

Polio ☐ Yes ☐ No

Severe reactions to insect bites ☐ Yes ☐ No

Typhoid ☐ Yes ☐ No

Mumps ☐ Yes ☐ No

Cystic Fibrosis ☐ Yes ☐ No

Chicken Pox ☐ Yes ☐ No

Scarlet Fever ☐ Yes ☐ No

Allergic skin Rashes ☐ Yes ☐ No

Gonorrhea ☐ Yes ☐ No

Liver disease ☐ Yes ☐ No

Angiodema ☐ Yes ☐ No

Other Health Problems ☐ Yes ☐ No

Syphilis ☐ Yes ☐ No

Arthritis ☐ Yes ☐ No

Jaundice ☐ Yes ☐ No

German measles ☐ Yes ☐ No

Other serious illness ☐ Yes ☐ No

Measles ☐ Yes ☐ No

Rheumatic fever ☐ Yes ☐ No

Diphtheria ☐ Yes ☐ No

Pneumonia ☐ Yes ☐ No

List any operations you have had, and the year performed: ______________________________

____

____

List any other hospitalizations and year: ______________________________

____

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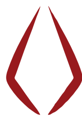

WOMEN ONLY – Menstrual History

Age of onset ______________ Date last period started _____________ Difficulties w/ periods? ☐ Yes ☐ No

Are you on Birth Control Pills? ☐Yes ☐No Number of pregnancies______ Number of Children ______

Were any illnesses or allergic symptoms made worse or better during pregnancy? ☐ Yes ☐ No

If yes, describe:

____

____

____

Is there any other pertinent information about exposure to environmental allergens that you can give us?

____

____

____

Please List all medications you are presently taking:

____

____

____

PLEASE BRING THIS FORM WITH YOU TO THE OFFICE AS WELL AS ALL THE MEDICATIONS YOU HAVE BEEN TAKING. REMEMBER, DO NOT TAKE ANY ALLERGY OR COLD MEDICATIONS FOR 4 DAYS PRIOR TO YOUR VISIT. THANK YOU.

Please Sign ____