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Allergy Patient Questionnaire

Name: _____ Date of Birth: _____ Today's Date: _____

Primary reason for today's visit: _____

Check your main symptoms- those that prompted your visit here:

Head or Nose

Chest

Skin

Insect Stings

- Sneezing
- Runny Nose
- Postnasal drainage
- Nose Blocking
- Sinus Infections
- Sore Throat
- Ear Blocking
- Snoring
- Nosebleeds
- Eye Symptoms

- Cough
- Wheezing
- Shortness of Breath
- Hoarseness
- Chest Infections
- Voice Loss

- Eczema
- Itching
- Swelling
- Hives

- Hives
- Swelling
- Shortness of Breath
- Itching
- Dizziness
- Fainting

How many **years** have you suffered from the chief complaints of:

Head or Nose symptoms _____

Chest symptoms _____

Skin symptoms _____

Insect Sting reactions _____

Please indicate pattern of symptoms - check those that apply to you:

Head/Nose

Chest

Year round, no seasonal change

Year round, worse seasonally

Seasonally only

If seasonally, list months: _____

Are your symptoms worse at night? Yes No

Do you note increased symptoms from any of the following?

Allergens

Irritants

Ingestants

Weather

- Mown grass
- Dead grass
- Dead leaves
- Hay
- House dust
- Cats
- Dogs

- Perfumes
- Soap
- Detergent
- Cleaning agents
- Smoke
- Paints
- Hair Spray

- Alcoholic Beverages
- Drugs
- Foods
- Other (list): _____
- _____
- _____

- Windy days
- Cold fronts
- Temperature Change
- Damp weather

Please check the ones that best describes your home:

House (Age: _____) Apartment City Country

Do you have a basement? Yes No

Type of heating system: Central Floor Electric Other: _____

Type of mattress: Conventional Waterbed

Type of pillow: Synthetic Down Do you have stuffed animals? Yes No

Do you have carpet in your home? Yes No Type: _____

Are your symptoms worse anywhere in your home? Yes No Location: _____

Do you have pets at home? Yes No What kind? _____

Where are your pets kept? Inside Outside

Are your symptoms worse at your workplace/school? Yes No

Have your symptoms been so severe as to cause you to miss work or school? Yes No

If so how many days? _____

Has travel affected your symptoms? Yes No

Do you have hobbies that expose you to allergens or irritants? Yes No

If yes, explain briefly: _____

List medicines you use for the relief of allergy symptoms (including nose drops or sprays):

Can you take aspirin? Yes No

Are you allergic to any medications? Yes No

If yes, please list: _____

What type of reaction occurs? _____

Have you ever taken allergy shots before? Yes No

Have you ever had a chest x-ray or CT scan? Yes No If yes, when? _____

Where? _____

Have you ever had a sinus x-ray? Yes No If yes, when? _____

Where? _____

Do you smoke? Yes No

If yes, how many packs per day? _____ How long? _____

Have you ever smoked? Yes No

If yes, how many packs per day? _____ How long? _____

Does anyone you live with smoke? Yes No

If yes, who? _____

Are you exposed to smoke at work or school? Yes No

Please mark the following if there is a history of any of these conditions in your family?

Asthma Hay fever Nasal polyps Eczema Hives

Indicate the family member (s) : _____

Have you ever been treated in an emergency room? Yes No

If yes, how many times? _____ For what reason? _____

List all hospitalizations in order of most recent:

Cause of hospitalization Age

Check any of the following that you might have had or have:

Stomach ulcer Diabetes Glaucoma High Blood Pressure

Check if you might have had or have any problems related to the following:

Blood Bones Heart Nervous system Urinary Tract

List any medical problems you have not noted above: _____
