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## Allergy Questionnaire

**Name**_____ **Age**_____ **Sex**_____ **Date**_____

### Instructions

Please answer the following questions completely and as accurately as possible. The information you give will be very important in learning more about your allergy and how to control it. NOTE: If you are filling this out for an infant or child, remember that he/she is the patient and not you. Also, in the family history, the relatives specified are the patient's relatives.

**Briefly describe the reason for this visit -** _____

### 1. Have you ever had . . . ?

| Yes | No | Check each item | Age of Onset | Months affected | Time of day |
|---|---|---|---|---|---|
| | | Hay fever (itching eyes or nose, sneezing, stuffy nose, running nose) | | | |
| | | Asthma (wheezing, frequent cough, chest tightness) | | | |
| | | Eczema, hives, or other rashes | | | |
| | | Sinus trouble or frequent colds | | | |
| | | Drug allergies (penicillin, aspirin, sulfa, tetanus, etc.) Which Drugs? | | | |

FOR PHYSICIAN - LEAVE BLANK _____

### 2. Have you ever had any of the following? Please check at left of each item

| | | |
|---|---|---|
| Infant Colic or Feeding Problems | Coughed up Blood | Surgery (tonsils, adenoids, PE tubes) |
| Recurrent ear infections | Heart Trouble | Operation on nose |
| Hearing Loss | High Blood Pressure | Chest X-ray Dx? |
| Pneumonia/Recurrent Bronchitis | Kidney Trouble | Date |
| Frequent Headaches | Liver Trouble | Sinus X-ray Dx? |
| Recurrent Diarrhea | Tuberculosis | Date |
| Frequent Tiredness | Noisy Breathing | Other Surgery |
| Frequently Dizzy or Lightheaded | Loss of smell or taste | Other Serious Illness |
| Frequent Stomach Trouble or Aches | Bed Wetting | |
| Grinds Teeth | Hyperactive | School Problems |

FOR PHYSICIAN - LEAVE BLANK _____

**3. Is there a history of allergies in your family? If yes, please list :** _____

| Allergy | Relation |
|---|---|
| Hayfever | |
| Sinus Problems | |
| Eczema | |
| Asthma | |
| Food Intolerance or Allergy | |
| Hives | |
| Headaches | |

**4. Have you ever had allergy skin tests?**

If yes, date _____ Doctor's name _____

Do you recall the results? If so, please list. _____

**5. Have you ever received allergy injections?**

If yes, dates _____ Did they help? _____

**6. Please list <u>all</u> medications that you are now taking?** _____

Do you ever use nose sprays? _____

**7. What other medications have you taken in the past for allergies?** _____

Which ones helped the most? _____

**8. What type of work do you do?** _____

Are you exposed to anything at work that may aggravate your condition? _____

Have much time have you missed from work/school because of your allergies?

**9. Where do you live? (Area of city or country)** _____

Type of heating: _____

Central air or other: _____

Type of rug & pad in bedroom: _____

Number of beds in your bedroom: _____

Is your pillow stuffed with feather, foam, dacron, synthetic, other? _____

Is your mattress stuffed with foam rubber, usual cotton, horse hair, other? _____

How old is your mattress? _____ Pillow? _____

Plants in the house? Describe: _____

**10. Do you have pets?** (Cats, dogs, birds, other) **How many?** _____

How much time are they indoors? _____

Where do they sleep? _____

Have you ever noted symptoms after being exposed to them? Describe: _____

FOR PHYSICIAN - LEAVE BLANK _____

**11. Possible allergic triggers - -** Please check the appropriate choice to show change in your condition when you are exposed to these elements.

| | Does not apply Not exposed to | Condition made worse | Condition Improved | No Change |
|---|---|---|---|---|
| Mowing the lawn | | | | |
| Playing in/on grass | | | | |
| Raking dead or damp leaves | | | | |
| High winds or windy weather | | | | |
| Sweeping, dusting | | | | |
| Barn dust | | | | |
| Chalk dust | | | | |
| Moldy or Mildewed areas | | | | |
| Contact or nearness to animals | | | | |
| Specify: | | | | |
| Air conditioning | | | | |
| Cold drafts/chilling | | | | |
| Trips away from home | | | | |
| Please describe: | | | | |
| Following a light rainfall | | | | |
| Following a heavy rainfall | | | | |
| Damp or humid weather | | | | |
| Cigarette Smoke | | | | |
| Does anyone in your home smoke? | | | | |
| Breathing cold air | | | | |
| Use of hair sprays, cosmetics, perfumes, | | | | |
| deodorants, aftershave - specify | | | | |
| Use of household cleaning agents, laundry | | | | |
| soap, etc. - specify | | | | |
| Use of varnish, paint, glues - specify | | | | |
| Strong odors - specify | | | | |
| | | | | |
| Emotional upsets or stress | | | | |
| Heavy physical exercise | | | | |
| Anything else you feel is relevant: | | | | |
| **Medications** | | | | |
| Taking of medication - be **very** specific! | | | | |
| Antihistamines or cold tablets | | | | |
| Nose sprays or drops | | | | |
| Asthma medications or sprays | | | | |
| Aspirin or related products | | | | |
| Others: | | | | |

**12. Have you ever noticed symptoms** (rash, runny nose, headache, cough, asthma, stomach ache, loose bowels, nausea) **after any of the following foods?**

**Check to the left of the following**

| | | | | | |
|---|---|---|---|---|---|
| Milk | Eggs | Wheat | Berries | Melon | Fish |
| Shell fish | Peanuts | Sugar | Tomatoes | Spices | Other nuts |
| Coffee | Mustard | Chocolate | Celery | Ginger | Corn |
| Fruits | Meats | Vegetables | Pastries | Alcohol | Wine |
| Beer | Cheese | Food Coloring | | | |

Please explain: _____

FOR PHYSICIAN - LEAVE BLANK _____

| Please mark appropriately | Like | Dislike | Eat/Drink in Large Quantities |
|---|---|---|---|
| Milk | | | |
| Chocolate | | | |
| Colas | | | |
| Corn | | | |
| Eggs | | | |
| Wheat/Oats | | | |
| Tomatoes | | | |
| Peanuts/Peanut Butter | | | |
| Citrus – Orange | | | |

Have you ever had poison ivy or poison oak? If yes, how frequently? When? _____
_____

**13. Have you ever smoked?** _____

What? (Cigarettes, cigars, pipe, etc.) _____
For how many years? _____
Average per day - _____
Do you still smoke? Yes _____ No _____
If you still smoke, do you think you could stop? _____ Would you like to quit? _____

**14. Have you ever been stung by a bee, wasp, yellow jacket, fire ant, or hornet?** _____
If yes, did you have any **unusual** reaction – very large swelling, hives, asthma, loss of consciousness? ___
_____

**15. When did you have your last –** Tetanus _____ Polio _____ Flu Shot _____
Pneumonia (Pneumococcal) Vaccination _____

**FOR PHYSICAN USE ONLY – LEAVE BLANK**

Physical Examination Ht. _____ Wt. _____ BP _____ Temp. _____ Resp. Rate _____
Pharnyx –
Sinuses –
Eyes –
Ears –
Nose – R Turbinates _____ Mucous _____ Septum-Appearance _____ Smear _____
L Turbinates _____ Mucous _____ Septum-Appearance _____ Smear _____
Heart –
Lungs –
Skin –
Other –

Impression

| Patient Information Material | Laboratory Studies |
|---|---|
| 1. Asthma | 1. CBC |
| 2. An explanation of allergies | 2. UA |
| 3. House dust control | 3. Immunoglobins |
| 4. Central Air Filter | 4. IgE (PRIST) |
| 5. Molds and Fungi | 5. Theophilline level |
| 6. Discussion of Hyposensitization | 6. ANA |
| 7. Eczema | 7. Sweat Chloride |
| 8. Hives | 8. Nasal Smear |
| 9. Headaches | 9. RAST |
| 10. A.C.T. Program | 10. Sed Rate |
| 11. Allergy elimination diet | 11. Complete Spirometry |
| 12. Food Allergy | 12. Chest X-Ray |
| 13. Allergic Tension | 13. Sinus X-Rays |
| 14. Stinging Insect Allergy | 14. Audiogram/Tympanogram |
| 15. Animal Danders | 15. SMAC – 24 |
| 16. Corticoseroids – topical/systemic | 16. Urticaria Evaluation |

**Recommendations:**

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_____