Department of Allergy & Immunology

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ALLERGY QUESTIONNAIRE

How were you referred? Physician (name) ________________ Self referral ________ Other ________

Do Not Write in this Section

What Problem brings you or your child to this appointment? ________________

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____

When did symptoms begin? ________________

Are your symptoms getting worse? ❑ Yes ❑ No

Do you have any of these symptoms? (Please check)

❑ Cough ❑ Runny Nose ❑ Nasal Polyps ❑ Eczema
❑ Wheezing ❑ Nasal Congestion ❑ Poor Sense of Smell ❑ Hives / Swelling
❑ Shortness of breath ❑ Itchy Nose ❑ Ear Infections ❑ Headaches
❑ Chest tightness ❑ Itchy / Watery Eyes ❑ Sinus Infections ❑ Snoring
❑ Sneezing ❑ Postnasal Drip ❑ Blocked Ears ❑ Fatigue
❑ Phlegm /Sputum (color) ________ ❑ Other

Check any of the following which seem to trigger (or cause) symptoms or bother you:

❑ Grass ❑ Cats ❑ Cosmetics ❑ Drafts ❑ Nervousness
❑ Hay ❑ Dogs ❑ Aerosol sprays ❑ House dust ❑ Cold Air
❑ Mold and Mildew ❑ Horses ❑ Perfumes ❑ Smoke ❑ Humidity
❑ Basements ❑ Other animals ❑ Insecticides ❑ Pollution ❑ Weather changes
❑ Leaves ❑ Alcoholic beverages ❑ Odors ❑ Exercise ❑ Latex (rubber)

Other ________________

When are your symptoms worse? ❑ Year Round

❑ January ❑ February ❑ March ❑ April ❑ May ❑ June
❑ July ❑ August ❑ September ❑ October ❑ November ❑ December

Are symptoms better away from home? ❑ Yes ❑ No If Yes, when? ________

Have you been skin tested? ❑ Yes ❑ No

Results: ________________

Have you had allergy injections? ❑ Yes ❑ No When: ________

Have you received cortisone (prednisone, methylprednisolone, etc.) drugs? ❑ Yes ❑ No

When ________ How much: ________

Occupation (current or former) ________________

Any harmful exposure at work or school: ________________

ENVIRONMENTAL SURVEY

How long have you lived in your house/apartment? ________________

Do you live in a ❑ House ❑ Apartment/Duplex ❑ Condominium/Townhouse

Approximately how old is your house/apartment/condo? ________________

Do you live ❑ In the city ❑ In the suburbs ❑ Rural areas

Do you have a basement? ❑ Yes ❑ No

Is your house built on a slab? ❑ Yes ❑ No

Type of heating system (check one) ❑ Hot Air ❑ Steam (radiator) ❑ Electric ❑ Hot water (baseboard)

Do you have: ❑ Wood /Coal Stove ❑ Humidifier ❑ Dehumidifier ❑ Air cleaner

Pets (number) – Indoor or Outdoor ❑ None ❑ Cats ____ ❑ Dogs ____ ❑ Birds ____ ❑ Other ____

Are there any tobacco smokers in your home? ❑ Yes ❑ No

Is your bedroom in the basement? ❑ Yes ❑ No

Do you have allergy proof encasing for pillow or mattress ❑ Yes ❑ No

What type of pillows do you have? ____________________

What type of comforter do you have? ____________________

What type of floor covering do you have **in your bedroom**? ❑ Wall to wall ❑ Area Rug ❑ Animal skin ❑ Bare floor

How old is your mattress? __________ What is in your mattress (i.e. cotton/horse hair) __________

Do you have air conditioning? ❑ Yes ❑ No If Yes, ❑ Window Unit ❑ Central

Do you have problems with roaches or mice ❑ Yes ❑ No

Do you have water leaks, mold contamination? ❑ Yes ❑ No

Is your home/apartment excessively humid? ❑ Yes ❑ No

Do Not Write in this Section

BW:

P/L/D:

BF:

Grade:

YOUR PAST MEDICAL HISTORY

Check all that apply:

❑ Diabetes	❑ Liver disease/hepatitis	❑ Peptic ulcer	❑ Heartburn/reflux
❑ Cancer	❑ Heart problems/murmur	❑ Thyroid disease	❑ Seizures
❑ High blood pressure	❑ Osteoporosis	❑ Arthritis	❑ Migraines
❑ Anemia/blood disorder	❑ Asthma	❑ Hay fever	❑ Depression
❑ Kidney/bladder disease	❑ Gynecologic problems	❑ Diarrhea	❑ Anxiety
❑ Back problems	❑ Glaucoma	❑ Cataracts	❑ Loss of hearing
			❑ Emphysema

If yes to any of the above, please explain:

____

____

Have you had your tonsils or adenoids removed? ❑ Yes ❑ No

Have you had ear, nose or sinus surgery ❑ Yes ❑ No

If Yes, please explain ____________________

____

FAMILY HISTORY

Who in your family has had: (**NOT** including yourself)

❑ Asthma ____________________

❑ Eczema ____________________

❑ Seasonal /year round allergies ____________________

❑ Other allergies (drugs/bee sting/food etc) ____________________

❑ Sinus problems ____________________

Please list any hospitalizations regardless of cause: ____________________

____

____

List any food allergies and reactions experienced: ____________________

____

____

List any drug allergies and reactions experienced (i.e. penicillin, aspirin, sulfa, latex, etc.): ____________________

____

Describe any reaction to insect stings: ____________________

____

List all medications and dosages (including nasal sprays, non-allergy medications and alternative/herbal products):

____

____

____

____

Do you smoke? ❑ Yes ❑ No How much? ____________________

Have you smoked in the past? ❑ Yes ❑ No When stopped? ____________________

If Yes, how many years have you smoked? ____________________

Patient Name: ____________________ Clinic #: ____________________

Date: ____________________ Questionnaire reviewed: ____________________