ALLERGY HISTORY QUESTIONNAIRE

Name: ___________________________ DOB: ______  DATE__________

PLEASE ANSWER ALL QUESTIONS TO THE BEST OF YOUR ABILITY. Complete this form prior to your appointment with your allergy specialist as the information will give us a better understanding of the problems you are experiencing.

Please indicate the symptoms you experience:

**EARS**

- Itching [ ] [ ]
- Drainage [ ] [ ]
- Fullness [ ] [ ]
- Popping [ ] [ ]
- Tubes placed [ ] [ ]
- Hard of hearing [ ] [ ]
- Frequent infections [ ] [ ]

# Ear infections/year ______

**NOSE/SINUS/FACE**

- Repeated sneezing [ ] [ ]
- Watery discharge [ ] [ ]
- Stuffy nose [ ] [ ]
- Itching [ ] [ ]
- Poor sense of smell [ ] [ ]
- Mouth breathing [ ] [ ]
- Snoring [ ] [ ]
- Facial pain [ ] [ ]
- Headaches [ ] [ ]

**CHEST**

- Cough [ ] [ ]
- Wheezing [ ] [ ]
- Sputum (phlegm) [ ] [ ]
- Shortness of breath
  - At rest [ ] [ ]
  - With exercise [ ] [ ]

**THROAT**

- Soreness [ ] [ ]
- Postnasal drip [ ] [ ]
- Itching roof mouth [ ] [ ]
- Strep infections [ ] [ ]
- # Strep throat infections per year______
- Hoarseness [ ] [ ]
- Tonsils removed [ ] [ ]
- Adenoids removed [ ] [ ]

**EYES**

- Contact lenses [ ] [ ]
- Itching [ ] [ ]
- Burning [ ] [ ]
- Watering [ ] [ ]
- Swelling [ ] [ ]
- Redness [ ] [ ]
- Discharge [ ] [ ]
- Glaucoma [ ] [ ]
- Cataract [ ] [ ]

**SKIN**

- History of hives [ ] [ ]
- History of eczema [ ] [ ]
- Problem with LATEX [ ] [ ]
- History of rashes [ ] [ ]
- History of itchy skin [ ] [ ]

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*Note: Please check the appropriate box for each symptom.*
SEASONAL INCIDENCE and Triggers
Please check off symptoms and when symptoms occur.

<table>
<thead>
<tr>
<th></th>
<th>YES</th>
<th>NO</th>
<th>March-May</th>
<th>May-July</th>
<th>August-October</th>
<th>November-March</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wheezing</td>
<td>[ ]</td>
<td>[ ]</td>
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<tr>
<td>Cough</td>
<td>[ ]</td>
<td>[ ]</td>
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<td>[ ]</td>
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<td>[ ]</td>
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<tr>
<td>Nasal</td>
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<tr>
<td>Headaches</td>
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<tr>
<td>Eyes</td>
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<td>[ ]</td>
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</tr>
<tr>
<td>Ears</td>
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<td>[ ]</td>
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<tr>
<td>Throat</td>
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<td>[ ]</td>
</tr>
<tr>
<td>Skin/Eczema</td>
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<td>[ ]</td>
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</tbody>
</table>

Do any of these items cause a rash?

<table>
<thead>
<tr>
<th>Item</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Softener sheets</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>• Soaps or laundry detergents</td>
<td>[ ]</td>
<td>[ ]</td>
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<tr>
<td>• Ointments or lotions</td>
<td>[ ]</td>
<td>[ ]</td>
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<tr>
<td>• Cosmetics</td>
<td>[ ]</td>
<td>[ ]</td>
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<tr>
<td>• Metals</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>• Poison ivy</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>• Food Allergies</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>• Medications</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>• Other*</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
</tbody>
</table>

*If yes, please list: __________________________

Do your symptoms get worse?

<table>
<thead>
<tr>
<th>Item</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>• In morning upon arising</td>
<td>[ ]</td>
<td>[ ]</td>
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<tr>
<td>• In dusty areas</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>• Being inside</td>
<td>[ ]</td>
<td>[ ]</td>
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<tr>
<td>• Near animals</td>
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<td>[ ]</td>
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<tr>
<td>• In basements</td>
<td>[ ]</td>
<td>[ ]</td>
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<tr>
<td>• In air conditioning</td>
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<td>[ ]</td>
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<tr>
<td>• In damp areas</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>• After raking leaves</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>• Being outside</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>• Around cut grass</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>• In humidity/ heat</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>• Season changes</td>
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<td>[ ]</td>
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<tr>
<td>• Weather changes</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>• Near perfumes/scents</td>
<td>[ ]</td>
<td>[ ]</td>
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<tr>
<td>• Around smoking</td>
<td>[ ]</td>
<td>[ ]</td>
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<tr>
<td>• Other</td>
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</tbody>
</table>

If yes, please list: __________________________

FOOD ALLERGIES/SENSITIVITIES: Do you have problems with any foods? If yes, describe problem. For instance: swelling or itching of the tongue, lips, or mouth? Rashes or hives? Immediate or delayed? vomiting or diarrhea?

Food: __________ Reaction: __________________________

Food: __________ Reaction: __________________________
ASTHMA HISTORY
Referring to: As a child [ ] Now ( ) No History of asthma ( )
If currently being treated for asthma, please complete the following:
# of hospitalizations or ER visits for asthma in the past year: ______________________
# of times per week you are awakened with asthma (wheeze, cough, shortness of breath) _______
# of times per week you use a rescue inhaler for acute asthma? ______________________
Date of last pulmonary function test: ________________________________

ALLERGY TESTING HISTORY
Have you had allergy testing before? YES [ ] NO [ ] If so, when? ______________________
Name of doctor who performed tests: ________________________________________________
His/her address of practice: _________________________________________________________
Kind of testing? Scratch, Intradermal, RAST. Circle one.
Were there any positive reactions? YES [ ] or NO [ ]
If so, to what? ___________________________________________________________________
Were you treated? YES [ ] or NO [ ]
If so, how? _______________________________________________________________________
Did you improve with treatment? ___________________________________________________

MEDICAL HISTORY
LIST ALL MEDICATIONS YOU ARE NOW TAKING:
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

Have you ever been treated in an emergency room for an allergic reaction?
YES [ ] NO [ ]
If so, give details. __________________________________________________________________
________________________________________________________________________________

ANIMALS/Pets: Does animal exposure make symptoms worse? NO ( ) YES ( ) If so, what type of animal and symptoms? ______________________
Do you have any pets? YES [ ] NO [ ] If yes, please list. ______________________________
How long have the pet(s) been with you?
_____________________________________________
Does the pet(s) have full use of the house? YES [ ] NO [ ]
Does the pet(s) sleep in your bedroom? YES [ ] NO [ ]
HOME AND WORK ENVIRONMENT:
Please specify H for Home and W for Work

Ventilation SYSTEM:
Electric _______ Gas _______ Oil _______ Other? Specify___________
Forced hot air _______ Hot water _______
Humidifier _______ Air conditioning _______ Electronic air cleaner _______
Basement:        Finished _____ Unfinished _____ Damp _____
Furniture Coverings: Fabric _______ Vinyl _______ Other? Specify.
Floor Coverings: Wall to wall carpeting _____ Wood floors _____ Carpeting_____
                    Area rugs _______ Tile_____
Window Coverings: Washable curtain/ drapes _____ Unwashable curtain/drapes_______
                    Shades _______ Venetian blinds _______ other? Specify.
                    Age of Home _______    Age of Work Building _______
Are symptoms increased at work, home or is there no change?  Circle one

HOME AND VISITING ENVIRONMENT:
Please specify H for Home and V for Visiting.

Beds and Bedding :
Number of beds (your room) _______ Stuffed animals_________
Comforter(s):   Down/Feather _____ Chenille bedspread _____ Cotton_______
                    Dacron /Polyester _____
Pillows :       Feathers or Down _____ Foam rubber _____ Dacron /Polyester _____
Mattress:       Innerspring _____ Foam Rubber _____ Polyester _____ Other? Specify.
Age of Mattress _______ Allergy Proof Covers? YES ( ) No ( )

Do you feel we have missed something that is pertinent to your symptoms?
Please list here:
____________________________________________________________________________
____________________________________________________________________________

After reviewing your answers, if you feel fully satisfied with the information provided, please bring this back to the office to be reviewed at the time of your testing visit.

THANK YOU!