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	YES	NO
• Itching	[ ]	[ ]
• Drainage	[ ]	[ ]
• Fullness	[ ]	[ ]
• Popping	[ ]	[ ]
• Tubes placed	[ ]	[ ]
• Hard of hearing	[ ]	[ ]
• Frequent infections	[ ]	[ ]

Ear infections/year _________

NOSE/SINUS/FACE	YES	NO
• Repeated sneezing	[ ]	[ ]
• Watery discharge	[ ]	[ ]
• Stuffy nose	[ ]	[ ]
• Itching	[ ]	[ ]
• Poor sense of smell	[ ]	[ ]
• Mouth breathing	[ ]	[ ]
• Snoring	[ ]	[ ]
• Facial pain	[ ]	[ ]
• Headaches	[ ]	[ ]

CHEST	YES	NO
• Cough	[ ]	[ ]
• Wheezing	[ ]	[ ]
• Sputum (phlegm)	[ ]	[ ]
• Shortness of breath	[ ]	[ ]
○ At rest	[ ]	[ ]
○ With exercise	[ ]	[ ]

THROAT	YES	NO
• Soreness	[ ]	[ ]
• Postnasal drip	[ ]	[ ]
• Itching roof mouth	[ ]	[ ]
• Strep infections	[ ]	[ ]
# Strep throat infections per year_____		
• Hoarseness	[ ]	[ ]
• Tonsils removed	[ ]	[ ]
• Adenoids removed	[ ]	[ ]

EYES	YES	NO
• Contact lenses	[ ]	[ ]
• Itching	[ ]	[ ]
• Burning	[ ]	[ ]
• Watering	[ ]	[ ]
• Swelling	[ ]	[ ]
• Redness	[ ]	[ ]
• Discharge	[ ]	[ ]
• Glaucoma	[ ]	[ ]
• Cataract	[ ]	[ ]

SKIN	YES	NO
• History of hives	[ ]	[ ]
• History of eczema	[ ]	[ ]
• Problem with LATEX	[ ]	[ ]
• History of rashes	[ ]	[ ]
• History of itchy skin	[ ]	[ ]

SEASONAL INCIDENCE and Triggers

Please check off symptoms and when symptoms occur.

	YES	NO	March-May	May-July	August-October	November-March
Wheezing	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Cough	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Nasal	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Headaches	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Eyes	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Ears	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Throat	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Skin/Eczema	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]

Do any of these items cause a rash?

	YES	NO
• Softener sheets	[ ]	[ ]
• Soaps or laundry detergents	[ ]	[ ]
• Ointments or lotions	[ ]	[ ]
• Cosmetics	[ ]	[ ]
• Metals	[ ]	[ ]
• Poison ivy	[ ]	[ ]
• Food Allergies	[ ]	[ ]
• Medications	[ ]	[ ]
• Other*	[ ]	[ ]

*If yes, please list: ____________________

____

Do your symptoms get worse?

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

If yes, please list: _______________

FOOD ALLERGIES/SENSITIVITES: 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 [ ]**

<u>HOME AND WORK ENVIRONMENT:</u>
Please specify **<u>H</u>** for Home and **<u>W</u>** 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 **<u>work</u>**, **<u>home</u>** or is there **<u>no change</u>**? **Circle one**

<u>HOME AND VISITING ENVIRONMENT</u>:
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!