

ALLERGY QUESTIONNAIRE

Patient Name: _____ Date: _____
Address: _____ Date of Birth: _____
City, State, Zip: _____ Home#: _____
Gender(circle one): MALE FEMALE Work#: _____
Primary Care Physician: _____ Referring Physician: _____

Please answer the questions on this form as they relate to the person being evaluated.

Although your history and symptoms are very important in our analysis of your condition, it is also important for us that you understand:

- *We do not treat symptoms or diseases.*
- *Allergy is not a disease, rather a condition.*
- *A symptom is an attempt by your body to tell you something.*
- *We will attempt to find the underlying cause.*
- *We do not use drugs in this program.*
- *There is no single “healthy” diet that will work for everyone.*
- *Just because food is considered “healthy”, does not mean it is “healthy” for you.*
- *Your diet consists of everything you **eat, drink, rub on your skin, or inhale.***
- *Our procedures are safe and painless.*

Briefly describe the reason for your visit and what you hope to accomplish: _____

MEDICAL HISTORY/SYMPTOMS REVIEW:

Do you have problems with a heart valve, heart murmur, or congenital heart disease? Yes No If yes, please explain: _____

Do you have an illness that affects your immune system? (Common Variable Immunodeficiency, HIV/AIDS, Other Immunodeficiency) Yes No If yes, please specify: _____

Do you have an autoimmune disease? (Lupus, Rheumatoid Arthritis, Sarcoid, Scleroderma, etc.) Yes No If yes, please specify: _____

Do you have cancer? (Lymphoma, Leukemia, Multiple Myeloma, other) Yes No If yes, please specify: _____

Have you ever had a bone marrow or solid organ transplant? (Lung, Kidney, Liver) Yes No If yes, please specify: _____

Do you have problems with your spleen, lack of spleen or sickle cell anemia? Yes No If yes, please specify: _____

Do you have chronic back pain, problems with your discs, sciatica or carpal tunnel? Yes No If yes, please specify: _____

Do you have recurrent or chronic problems with any of the following?

- | | | |
|---|--|---|
| <input type="checkbox"/> Frequent Headache | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Heartburn/Reflux |
| <input type="checkbox"/> Vision Disturbance/Cataracts | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Wear Glasses | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Wear Contact/Soft/Gas Perm | <input type="checkbox"/> Rapid Heart Beat | <input type="checkbox"/> Frequent/Painful Urination |
| <input type="checkbox"/> Frequent Cold, ____/Year | <input type="checkbox"/> Nausea/Vomiting | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney/Bladder Disease | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Anemia/Blood Disorder | <input type="checkbox"/> Liver Disease/Hepatitis | <input type="checkbox"/> Heart Problems/Murmur |
| <input type="checkbox"/> Gynecologic Problems | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Hay Fever |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Migraines | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Peptic Ulcer | <input type="checkbox"/> Loss of Hearing | <input type="checkbox"/> Emphysema |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Nausea/Vomiting | <input type="checkbox"/> Arthritis |

If yes to any above, please explain: _____

Briefly explain any other chronic symptoms: _____

AGE WHEN SYMPTOMS WERE FIRST OBSERVED

- Infant (Age 0 -2)
- Child (Age 3 – 5)
- Child (Age 6 – 12)
- Adolescent (Age 13 – 18)
- Adult (Age 19 – 25)
- Adult (Age 26 – 40)
- Adult (Age 40)

PREVIOUS DIAGNOSIS OF ALLERGY

- Yes, and allergy shots helped.
- Yes, but allergy shots did not help
- Yes, and medication helped
- Yes, but medication did not help
- None

FAMILY MEMBERS WITH ALLERGIC SYMPTOMS

- Mother
- Father
- Brother/Sister
- Grandparents
- Son/Daughter
- Spouse
- None

SKIN SYMPTOMS

- Hives
- Rashes
- Itching
- Eczema
- Swelling
- Sores
- Once had rashes in the bends of knees and elbows
- Above symptoms are worse during known pollen seasons
- Above symptoms are worse with animal exposure
- Skin problems are rare
- Skin problems are chronic
- None

EYE SYMPTOMS

- Itching
- Excessive Watering
- Redness
- Swelling
- Above symptoms are worse during known pollen seasons
- Above symptoms are worse with animal exposure
- Tobacco smoke or chemical exposure makes symptoms worse
- Tobacco smoke or chemical exposure is the major cause of symptoms
- None

NASAL SYMPTOMS

- Itching
- Sneezing
- Runny Nose – Clear Discharge
- Frequent Nose Blowing
- Above symptoms are worse during known pollen seasons
- Above symptoms are worse with animal exposure
- Runny Nose – Cloudy Discharge
- Stuffiness
- Post Nasal Drip
- Frequent Sinus Infections
- Nasal Obstruction
- Loss of Smell
- None

EAR SYMPTOMS

- Itching
- Blocking, Fullness and Popping
- Hearing Loss
- Pain
- Frequent Ear Infections
- Ear Tubes Inserted
- Ringing in Ears
- None

THROAT & MOUTH SYMPTOMS

- Itching of the throat or mouth
- Frequent Sore Throats
- Frequent Laryngitis
- Frequent Tonsillitis
- Mouth Sores
- Swelling of the Tongue or Mouth
- None

CHEST SYMPTOMS

- Tightness
- Asthma or Wheezing with exercise
- Asthma or Wheezing when around animals
- Asthma or Wheezing during pollen seasons
- Asthma or Wheezing when around tobacco smoke or chemicals
- Shortness of Breath
- Dry Coughing
- Wet Coughing
- Emphysema
- Frequent Bronchitis
- Recurring Pneumonia
- Chest Pain
- None

CHRONIC GASTROINTESTINAL SYMPTOMS

- Nausea and Vomiting
- Diarrhea
- Gas, Heartburn
- Cramps or Bloating
- Abdominal Pain
- Re-taste Foods
- None

BONE & JOINT SYMPTOMS

- Joint or Bone Pain
- Muscle Pain
- Redness or Swelling of Joints
- Joint Stiffness, Limited Motion
- None

FREQUENCY & SEVERITY OF ALLERGY SYMPTOMS

- Constant, Chronic with Little Change
- Present Most of the Time
- Present Part of the Time
- Present Rarely
- No Interference with Normal Life
- Slight Interference with Normal Life
- Considerable Interference with Normal Life
- Prevents Some Normal Activities

SYMPTOMS ARE WORSE

- Outdoors, and better indoors
- At nighttime
- In the bedroom or when in bed
- During windy weather
- During wet or damp weather
- When the weather changes
- During known pollen seasons
- In certain rooms or buildings
- When exposed to tobacco smoke
- With yard work, cut grass, leaves, hay or barns
- When sweeping or dusting the house
- In areas with mold or mildew
- In air conditioning
- In fields or in the country
- Tobacco smoke bothers me more than anything else
- Don't know

SYMPTOMS ARE BETTER

- After shower or bath
- In air conditioning
- Indoors
- During or after physical activity
- After taking antihistamines
- With allergy shots
- Don't know

ANIMALS, INSECTS AND BIRDS THAT CAUSE SYMPTOMS ON EXPOSURE

- Dogs
- Cats
- Horses or Cattle
- Rodents (mice, guinea pigs, etc.)
- Rabbits
- Birds or Feathers
- Bees
- Other _____
- None

FOOD RELATED SYMPTOMS

- Symptoms flare 5 – 60 minutes after meals
- Some foods are craved or addictive
- The smell or odor of some foods increases symptoms
- Preservatives, additives or food coloring increase symptoms
- Some foods cause nasal symptoms
- Some foods cause asthma
- Some foods cause rashes or hives
- Some foods cause headaches
- Some foods cause swelling of mouth or tongue
- Some foods cause upset stomach or vomiting
- Some foods cause diarrhea
- Symptoms occur with restaurant salad bars or Asian foods
- Symptoms occur with any regularly eaten food
- None

FOODS THAT CAUSE SYMPTOMS WITHIN 1 – 2 HOURS

- Eggs
- Milk
- Beef
- Corn
- Wheat
- Soybean
- Peanut
- Pork
- Fish
- Shellfish
- Orange or other citrus
- Potato
- Tomato
- Yeast
- Chocolate
- Coffee or Tea
- Other: _____

FOODS THAT CAUSE SYMPTOMS WITHIN 2 – 24 HOURS

- Eggs
- Milk
- Beef
- Corn
- Wheat
- Soybean
- Peanut
- Pork
- Fish
- Shellfish
- Orange or other citrus
- Potato
- Tomato
- Yeast
- Chocolate
- Coffee or Tea
- Other: _____

CHEMICALS THAT CAUSE SYMPTOMS

- Insecticides & Pesticides
- Paints & Household Cleaners
- Perfumes & Cosmetics
- Gasoline or Automobiles Exhaust
- Stove or Furnace Emissions
- The Smell of New Fabrics or Fabric Store
- Chemicals in the workplace
- Laundry Detergent
- Newsprint
- Other: _____
- None

- When are your symptoms worse:
- | | | |
|----------------------------------|-----------------------------------|------------------------------------|
| <input type="checkbox"/> January | <input type="checkbox"/> February | <input type="checkbox"/> March |
| <input type="checkbox"/> April | <input type="checkbox"/> May | <input type="checkbox"/> June |
| <input type="checkbox"/> July | <input type="checkbox"/> August | <input type="checkbox"/> September |
| <input type="checkbox"/> October | <input type="checkbox"/> November | <input type="checkbox"/> December |

Have you had your tonsils or adenoids removed? Yes No
 Have you had ear, nose or sinus surgery? Yes No If yes, please explain: _____

What is your current weight? _____ What was your weight 1 year ago? _____

When was your last chest x-ray? _____ Results? _____

Have you ever had sinus x-rays? (Check one) Yes No If yes, please explain: _____

MEDICATIONS:

Do you take any of the following medications on a regular basis?

- Antihistamines
(Benadryl, Actifed, Chlortrimeton, Tylenol Sinus, Tylenol Sleep, Dimetapp, Drixoral, Trimalin, Atarax, Claritin, Allegra, Zyrtec, etc.)
- Bronchodilators
(Albuterol, Ventolin, Proventil, Serevent, or OTS's such as Primatine Mist, etc.)
- Steroid Inhalers
(Asmacort, Flovent, Pulmicort, Beclovent, Aerobid, Advair, etc.)
- Nasal Steroids
(Beconase, Flonase, Nasacort, Rhinocort, etc.)
- Medications that affect the immune system
(Prednisone, Imuran, Methotrexate, Cellcept, Cytoxan, Cyclosporine, Tacrolimus, etc.)
- Chemotherapy

Please list any medications that you are currently taking: _____

SOCIAL:

Where were you born? _____ Where were you raised? _____

Where have you lived? _____

Check applicable box: *Single* *Married* *Divorced* *Widowed*

How many children to you have? _____ What are their ages? _____

Do you exercise? Yes No If yes, how often? _____/week How long? _____ workout

Do you drink alcohol? Yes No If yes, how often? _____times/week How much? _____ drinks/day

SMOKING:

Do you presently smoke? Yes No If yes, average number of cigarettes per day: _____

If yes, at what age did you start? _____

Have you ever smoked? Yes No If yes, how many years? ____ When did you quit? _____

Average number of cigarettes that you smoke per day: _____

Does anyone smoke in your home? Yes No

Have you ever had a reaction to x-ray dye? Yes No If yes, please explain: _____

PREVIOUS ALLERGY EVALUTION:

Have you ever seen an allergist? Yes No If yes, allergist's name: _____

Have you had allergy skin testing? Yes No If yes, Date: _____

Did you have any positive reactions? Yes No If yes, please list positive allergens (include any medications): _____

Have you ever received allergy injections? Yes No

If yes, did your symptoms improve while receiving injections? Yes No If yes, please explain:

Have you ever received Cortisone? (Prednisone, Methylprednisolone, etc.) drugs? Yes No If yes, how long ago? _____ How much? _____

ENVIRONMENTAL SURVEY:

Do your symptoms disturb your sleep? Yes No

Are your symptoms better when away from home? Yes No

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

How long have you lived in your house/apartment/condominium? _____

Do you live in: The City The Suburbs Rural Area

Do you have a basement? Yes No Is your house built on a slab? Yes No

Type of heating system: Hot Air Steam (radiator) Electric Hot Water (baseboard)

Do you have: Wood/Coal Stove Humidifier Dehumidifier Air Cleaner

PETS:

(This section is only for those who own any pets)

How many of the pets do you own?

Cats _____ Dogs _____ Birds _____ Other _____

Are they indoor or outdoor pets? _____

SCHOOL HISTORY:

Do you attend school? Yes No If yes, at what grade level? _____

Is your classroom: Carpeted Tile Other Are there any animals in your classroom? Yes No

Have you missed school due to allergies or asthma? Yes No If yes, how many days did you miss last year because of allergies or asthma? _____

WORK ENVIRONMENT:

What is your occupation? _____

Where are you employed? _____

How long have you worked there? _____

Is your workplace: Carpeted Tile Other

Is there air conditioning? Yes No Is smoking permitted? Yes No

Are you exposed to chemicals or strong odors? Yes No If yes, briefly explain: _____

Are your symptoms worse while at work? Yes No If yes, briefly explain: _____

Have you missed time from work due to allergies or asthma? Yes No If yes, how much time have you missed in the past year? _____

IF THE PATIENT IS A CHILD, PLEASE COMPLETE THE FOLLOWING:

Place of Birth: _____ Mother's Age at Birth: _____

Was Pregnancy/Labor/Delivery Normal? Yes No If no, please explain: _____

Birth Weight: _____ Formula or Breast Fed? _____ Well Tolerated? _____

Has child reached normal growth milestones? Yes No If no, please explain: _____

Your relationship to child: _____