ALLERGY QUESTIONAIRE

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 carpel tunnel? □Yes □No If yes, please specify:____

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

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

☐ January	☐ February	☐ March
☐ April	☐ May	☐ June
☐ July	☐ August	☐ September
☐ October	☐ November	☐ 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?____

ADDITIONAL INFORMATION

Please use this page to fill out any additional information that you feel may be pertinent.

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:____