



Allergy Questionnaire

Patient's Name:	Date of Birth:
Address:	Telephone Home: Work:
Referring Physician:	Date of Appointment:

1. Instructions: Please answer the questions as they relate to the person being evaluated. A complete, accurate record is important in learning about your allergy problems. **Bring this completed form with you to your first appointment.**

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

2. Problems: Have you ever had the following conditions?

Yes	No	Check all items	Age at Onset	Severity			Comments
				Mild	Mod	Sev	
		Asthma (Wheezing)					
		Breathing Problems-Shortness of breath, cough					
		Sinus Trouble					
		Hay Fever (runny/stuffy/itchy nose; sneezing)					
		Hives or Swelling					
		Eczema or Other Rashes					
		Recurrent/Frequent Infections (sinus, ear)					
		Reactions to Foods					
		Reactions to Drugs					
		Reactions to Insect Stings					

3. Symptoms: Have you ever had any of the following? If not, leave blank.

	How many days last month?	Severity			Circle the Most Severe Months
		Mild	Mod	Severe	
Runny or Stuffy Nose					J F M A M J J A S O N D
Itchy Nose					J F M A M J J A S O N D
Sneezing					J F M A M J J A S O N D
Sinus Pressure Headaches					J F M A M J J A S O N D
Eyes: Red Watery Itchy					J F M A M J J A S O N D
Wheezing					J F M A M J J A S O N D
Coughing					J F M A M J J A S O N D
Wheezing or coughing with exercise					J F M A M J J A S O N D
Skin Problems					J F M A M J J A S O N D

4. Medications: List all medications you are taking now by Name, Dosage, Times per day

Present medication for allergies:	Name of Medication	Dosage	Times per Day
Medication taken in the PAST for allergies:			
Present medications for other reasons:			

5. Previous Allergy Evaluation and Therapy

Have you ever had Allergy Skin Tests? YES NO If YES - When?: RAST testing? YES NO If YES - When?:

Physician: Please list the results of testing: (If possible, please provide copies):

Have you ever received ALLERGY INJECTIONS? YES NO If YES: Please give dates: from to

6. Precipitating Factors (Triggers)

Check each Symptom Box which applies when you are exposed to:	Asthma	Nose - Ears Eyes - Throat	Headache	Eczema	Hives	Other
A. ENVIRONMENTALS						
1. Dust exposure: sweeping, vacuuming, making the bed.						
2. Molds: mildewed areas, raking leaves						
3. Animal Dander						
4. Outdoor exposure: pollens: grass, trees, weeds						
B. WEATHER/ENVIRONMENTAL CHANGES						
1. High winds						
2. Humidity						
3. Cold dry air						
4. Air conditioning/heating						
C. RESPIRATORY INFECTIONS/COLDS						
D. PHYSICAL EXERTION						
E. IRRITANTS: Tobacco smoke/strong odors/cleaning agents/aerosols/chemicals/pain						
F. POLLUTANTS: Smog/motor fumes/ozone/sulfur dioxide/ nitrous oxide						
G. FOODS: Food additives, colorings, preservatives						
H. EMOTIONAL EXPRESSIONS (Laughter, crying)						
I. STRESS						
J. HORMONAL FACTORS: 1. Menses						
2. Other:						
K. MEDICATIONS:						
1. Aspirin or NSAIDs						
2. OTHER:						
K. OTHER TRIGGERING FACTORS NOT LISTED:						

7. Review of Systems *(Circle each word which applies in each category.)*

Part A -- EPF: Pertinent to present problems/extended category.

General Health	Excellent Good Fair Poor
Full Body	Fever Chills Fatigue Weakness Night sweats
Head	Headache Trauma Sinus pressure

9. Past Medical History

A. Please list other Illnesses or Chronic Medical Conditions you have had:

B. List all hospitalizations/surgeries: Please list most recent first with reason and date.

1.

2.

3.

4.

C. Immunizations: Did you experience any significant Allergic Reaction to any administered vaccine? If YES, please note what type of reaction to which vaccine.

1. Are your immunizations up to date? YES NO

2. Date of last TETANUS: _____

3. Date of last TB TINE: _____

Indicate here any reactions to vaccines you have experienced:

10. Family History

Do any members of your family have a history of allergy?

	YES	NO	If YES, list all relatives (parent, grandparent, brother, sister, children, aunt, uncle)
Asthma			
Hay Fever			
Eczema			
Hives			
Frequent pneumonia, Sinus/ear infections			
Headaches			
Other Allergies:			

Is there a family history of any other illnesses?

	YES	NO	If YES, list all relatives as described above.
Emphysema/Other Lung Diseases/Tuberculosis			
Cystic Fibrosis			
Cardio-vascular Disease			
Thyroid Disease			
Glaucoma			
Diabetes			
Other:			

11. Environmental Survey

Where do you live? City Rural	Age of your house? _____ years _____ months	House construction: (brick, wood, etc.)	Type of heating: Forced air Steam Electric Space heater Baseboard Other:
Type of Air Conditioning: Central Window	Do you have an: a. AIR CLEANER? Central Window Unit b. HUMIDIFIER? Central Window Unit	Are any rooms damp or musty? YES NO If yes, which ones.	How many indoor plants do you have in the house?

Type of Carpet: Wool Synthetic Jute Other: _____

Wall to Wall: YES NO Is entire house carpeted? YES NO

Please list all rooms where carpeting is located:

Type of Carpet Pad: Rubber Ozite Hair Other: _____

Only indicate rooms if different from carpeting locations:

Do you have any Stuffed furniture/soft upholstered/pillows? YES NO Which:

Do you have any Feather Comforters? YES NO Do you have DOWN jackets/clothing? YES NO

Is your mattress: Foam rubber Innerspring & cotton Cotton Waterbed Other:

How old is your mattress? _____ years _____ months Is it encased in plastic: YES NO

What kind of grasses, shrubs, trees, and weeds grow in the immediate vicinity of your home?

Do you have any pets? If YES, list number and kind (dog, cat, bird, horse, etc.):

Do your pets spend time INDOORS? YES NO Are they allowed in the bedroom? YES NO

12. Social/Occupational/Educational History

12 a. Residence: List your past residences (city, state) with most recent first.

City/Town & State Urban or Rural # of Years Effect on Symptoms (Better,Worse, No Change)

1.

2.

3.

4.

12 b. Occupational History: Please list present occupation first, then past occupations.

Brief Job Description How long? Effect of workplace on symptoms

1.

2.

3.

Are you exposed to anything at work which might aggravate your condition? If YES, what are they?

Have you missed any work or school due to your allergies and/or asthma? If YES, how much time in the past 12 months?

Do you have any other exposures from hobbies or recreational activities? Please list.

13. Psychological Profile

Please circle all words you would use to describe yourself (or your child if he/she is being evaluated).

Timid	Well adjusted	Anxious
Quiet	Few friends	Many friends
Aggressive	Spoiled	Shy
Forward	Dependent	Relaxed
Unfriendly	Concerned	Independent
Introvert	Depressed	Manipulative
Tense	Bustling	Extrovert
Calm	Happy	Usually ill

12. Social/Occupational/Educational History (continued)

12 c. Education: Please indicate highest grade completed.

Grade School: _____ High School: _____ College: _____ Other: _____

12 d. Marital Status: Single Married Separated Widowed Number of children: _____

12 e. Sexual Behavior: Heterosexual Bisexual Homosexual NONE

12 f. Tobacco Smoking History:

Do you presently smoke? YES NO If YES, how many years have you been smoking? _____ years

Have you ever smoked? YES NO If YES, when did you stop? _____

Average cigarettes per day at highest point: _____

If you still smoke, do you think you could stop? YES NO

Do any family members living with you now smoke? YES NO If yes, which ones?

12 g. Do you now or have you ever used recreational drugs? YES NO If YES, were they: Oral Nasal IV



Spirometry Contraindication Sheet

Patient Name: _____

Date: _____

Have you recently had any of the following:

Coughing up blood: Yes / No

Heart disease: Yes / No

Is your heart in stable condition: Yes / No

Heart Attack: Yes / No

Acute lung disease: Yes / No
(such as pneumonia or emphysema)

Blood clots in the lung: Yes / No

Aneurysms of the Chest, Abdomen, or Head: Yes / No

Recent Chest or Abdominal Surgery: Yes / No

Eye surgery: Yes / No

Recent detached Retina: Yes / No

Glaucoma: Yes / No

Diagnosed with Asthma: Yes / No

Physician who is currently treating you: _____

Are you on medications for Asthma: Yes / No

Name of medication(s): _____

Have you recently had a breathing test for Asthma: Yes / No

Patient Signature: _____ Date: _____