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ALLERGY QUESTIONNAIRE

INSTRUCTIONS: Carefully complete in full. Accuracy and thoroughness are essential. Print all answers. Relate answers to your own experience, not to previous advice or skin tests. Fill out and handcarry for appointment. ALL INFORMATION WILL BE CONSIDERED CONFIDENTIAL.

Name _____ Address _____ City _____ State _____ Zip Code _____

Age _____ Sex _____ Occupation _____ Second Job _____ Telephone _____ Date _____

Family physician or pediatrician: _____
Name _____ Address _____

Referred by: Self, Friend _____ Physician _____
Name _____ Address _____ Name _____ Address _____

STATE PROBLEM(S) YOU WISH TO DISCUSS: _____

I. **SYMPTOMS: Circle Symptoms Brought On By Your Problem:**

GENERAL: Nervousness, Fatigue, Poor Appetite, Frequent Colds, Fever, Weight Loss, Sweats, Other _____

HEADACHE: TYPE: Dull - Sharp - Steady - Throbbing - Pressure. WHERE: Forehead - Around eyes - Below eyes - Temples - Top of head - Neck - Both sides - One side (L - R). FIRST BEGAN: Date _____. PATTERN: Intermittent - Constant over weeks or months - Seasonal (specify _____) - Night - Day - Both. CAUSE: Drinking alcohol - Tension - Nasal congestion - Fatigue - Eye Strain - Migraine - Hormonal. ASSOCIATIONS: Soreness of neck muscles - Spots before eyes - Nausea and/or Vomiting. FREQUENCY: _____ times per day / month / year. Do they wake you up at night: Yes - No. Seizures - Loss of Consciousness - OTHER: _____

EYES: One eye - Both eyes. Tearing, Burning, Itching, Pain, Redness, Discharge, Puffiness Blurring of Vision, Glaucoma, Cataracts, Circles Under Eyes, Swelling, Contact Lenses, Other _____

EARS: Left - Right - Both. Decreased Hearing, Frequent Infections, Popping, Pressure, Itching, Aching, Ringing of Ears, Other: _____

NOSE: Sneezing, Discharge (Left - Right - Both Sides) (Clear - Yellow - Green), Congestion, Tickling, Polyps, Sinusitis, Trouble Smelling, Post-nasal Drip, Deviated Septum, Broken Nose, Mouth Breathing, Other: _____

MOUTH: Itching of Roof, Repeated Tonsillitis, Tonsils Removed _____ (age), Morning Sore Throat, Swollen Lip, Trouble Swallowing, Hoarseness, Throat Swelling, Throat Itching, Frequent Throat Clearing, Other: _____

COUGH: Involuntary - Voluntary; Dry - Productive; MUCUS: None, Green, Bloody, Yellow, Clear. AMOUNT PER DAY: Teaspoon - Tablespoon - 1/2 cup. TIMING: Night time - Day time; with exercise, with laughing, lying down. Other: _____

CHEST: Shortness of breath, Chest tightness, Wheezing: With exercise - At rest - Bedtime, Chest pain, Hypertension, Heart disease, T.B., Ankle swelling, Other: _____

SKIN: Rash, Hives, Eczema, Swelling, Burning, Itching, Scaling, Other: _____

STOMACH: Heartburn, Acid indigestion, Hiatal hernia, Vomiting, Gas cramps, Gallstones, Diarrhea, Mucus in stool, Nausea, Blood in stool, Worse after eating what foods: _____ Nausea

URINE: Pain, Burning, Frequent urination, Bladder infections, Itching, Bedwetting, Enlarged prostate; Difficulty passing your water? Yes - No.

PSYCH: Refer to Emotional Factors page 3.

OTHER: Please describe other symptoms not listed above: _____

II. **ONSET AND DURATION:** *Circle pertinent items and fill in the blanks:*

- A. When did symptoms first begin _____ (year)?
- B. Underline months you have symptoms and their severity: Mild Moderate Severe
Jan. Feb. March April May June July Aug. Sept. Oct. Nov. Dec.
- C. Are you worse certain times of day, certain days of week, or certain weeks of the month?
Please specify: _____
- D. Are symptoms improved by major geographic changes or vacations? Yes - No
- E. Are you worse at work, home or school? Yes - No. Please specify: _____
- F. Course of illness over last year: ____ Daily, ____ Off - On, ____ Chronic, ____ Progressive.

III. **CIRCLE TERMS WHICH MAKE YOUR PROBLEM WORSE:**

- IRRITANTS:** Cigarette smoke, Perfume odors, Paints, Chemicals, Exercise, Emotional upset, Insect sprays, Very cold liquids, Infections, Other: _____
- FUNGI:** Mowing lawn, Raking leaves, Camping, Barns, Compost, Basements, House dusting, Beer, Wine.
- ANIMALS:** Cats, Dogs, Other: _____
- DRUGS:** Aspirin-containing compounds, Phenylbutazone, Indomethacin, Novacaine, Others: _____
- WEATHER:** Cold air, Rain, Change in Temperature, Wind, Frontal systems, Other: _____
- FOOD:** Please specify foods and reactions to them: _____

What do you think makes your symptoms worse: _____

Under what circumstances are you free of symptoms: _____

IV. **CURRENT MEDICATIONS:** *List all medications you take including sprays, nosedrops, vitamins, eye drops laxatives, birth control pills, etc.*

<u>Name</u>	<u>Times used per day</u>	<u>Name</u>	<u>Times used per day</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

- B. Circle the above medications which improve your symptoms.
- C. Last Chest x-ray: Date: ____ Mo. ____ Year. Normal / Abnormal _____
- D. Last Sinus x-ray: Date: ____ Mo. ____ Year. Normal / Abnormal _____

V. **SEVERITY OF SYMPTOMS:**

- A. ____ Number of hospitalizations for problem.
List date _____
- B. ____ Number of emergency room visits in last year for your problem.
- C. ____ Number of days missed from school or work due to your problem in last year.
- D. ____ Number of times your illness has required treatment with cortisone.
- E. ____ Episodes of pneumonias documented by shadows on chest x-ray.
- F. ____ Episodes of sinusitis documented by abnormal sinus x-ray.

VI. **DRUG ALLERGIES:** *List medications to which you are allergic and describe the adverse reaction to the drug:*

<u>Medication</u>	<u>Describe Reaction</u>	<u>Medication</u>	<u>Describe Reaction</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

VII. **ENVIRONMENTAL & SOCIAL HISTORY:** Circle pertinent items and fill in the blanks:

- A. WHERE DO YOU LIVE: House, Condo, Apartment, Duplex, Dormitory, Room, Mobile Home. How long have you lived there _____(years)? Age of dwelling _____(years)? How long have you lived in this area _____(years)? If a part-time resident, where is your other home. _____
- B. LOCATION: City, Suburbs, Country, Farm. Near: Factory, Bakery, Grain Storage, Swamp, Poultry Yard, Barn, Other _____
- C. TYPE OF HEATING: Forced air, Space heater, Radiator, Electric, Wood, Kerosene
TYPE OF AIR-CONDITIONING: None, Central, Window, Humidifier, Dehumidifier
- D. BEDROOM: Pillow: Feather, Foam, Dacron. Mattress: Foam, Innerspring, Waterbed. Vinyl Covers on Mattress & Pillow, Stuffed Toys. Blankets: Cotton, Polyester, Wool, Feather comforter.
- E. PETS: Which of these do you have as pets: Dogs, Cats, Bird, Hamster, Rabbit, Gerbil, Other _____
Which pets are allowed inside the house: _____
Which pets are allowed inside the bedroom: _____
- F. OCCUPATIONAL EXPOSURE: Stress, Tension, Strong Odors, Industrial Gases, Fumes, Talc, Paint Sprays, Silica, Fiberglass, Asbestos, Solvents, Pigeons, Poultry, Moldy Hay, Silos, Barns, Detergents, Latex, Other: _____
- G. SMOKING HABITS: (Circle) Cigarettes, Cigars, Pipe. Inhale: Yes - No. Number/day _____ How long? _____ (years). If you formerly smoked, when did you stop? _____ (year). Who else in household smokes? _____ Are you exposed to smoke at work _____? Socially _____?

H. HOBBIES:

Self	Spouse or Parent	Children	Others at Home

I. SOCIAL HABITS:

	Yes	No	If yes, specify amount per day
Do you: Drink coffee / tea / colas	_____	_____	_____
Drink beer / wine	_____	_____	_____
Drink liquor	_____	_____	_____
Use illicit drugs	_____	_____	_____

- J. EMOTIONAL FACTORS: Tension, Worries, Depression, Financial problems, Marital or sexual problems, Family problems, Problems at work or school, Always tired, Cry easily, Other: _____

VIII. **PAST MEDICAL HISTORY:**

- A. Childhood (Circle). Eczema, Bronchitis, Hay Fever, Asthma, Cystic Fibrosis, Other: _____
- B. Circle any medical conditions you have had diagnosed in the past or present. Specify age of occurrence.

<u>Age</u>	<u>Age</u>	<u>Age</u>
___ Diabetes Mellitus	___ Stomach or duodenal ulcer	___ Glaucoma
___ Tuberculosis	___ Kidney disease	___ Cataracts
___ Pneumonia	___ Cancer	___ Other _____
___ Heart Disease	___ Hypertension	___ Other _____
- C. List any illnesses or operations for which you have been hospitalized and your age at that time. (Women: Do not list normal pregnancies)

<u>Age</u>	<u>Cause</u>	<u>Age</u>	<u>Cause</u>	<u>Age</u>	<u>Cause</u>
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
- D. Have you ever had an allergic reaction to dye injected into your body for an x-ray procedure? Yes - No. If yes, when? _____ (year). Name of hospital? _____

