ALLERGY QUESTIONNAIRE

Allergy Affiliates
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All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name *(Last, First, M.I.):*	☐ M ☐ F	DOB:
Primary physician's name	If patient is a child, this form is being completed by ☐ mother ☐ father	
Who referred you to this practice? ☐ primary doctor ☐ friend/family ☐ ins co ☐ web		Your occupation:

What is the main reason for today's visit? (provide details)

Upper Respiratory Problems (Nose, sinus, ears, eyes)

Check box if not applicable ☐

☐ nasal congestion ☐ runny nose ☐ post nasal drip ☐ itchy nose ☐ red or itchy eyes	☐ sinus pressure or pain ☐ poor sense of smell ☐ frequent ear infections ☐ frequent sinus infections ☐ frequent colds	☐ hoarse voice ☐ other

Lower Respiratory Tract Problems (Chest, lungs)

Check box if not applicable ☐

☐ frequent or constant cough ☐ wheezing ☐ chest tightness ☐ shortness of breath	☐ asthma ☐ frequent croup ☐ pneumonias ☐ frequent bronchitis	☐ other:

Are the above symptoms seasonal? Jan Feb Mar April May June July Aug Sept Oct Nov Dec ☐ All Year ☐ No Pattern

Are the symptoms triggered by any of these?

☐ pollen ☐ animals ☐ dust ☐ mold ☐ smoke or scents ☐ weather changes ☐ foods

Skin Problems

Check box if not applicable ☐

☐ eczema ☐ itching skin rash ☐ dry skin ☐ itchiness in general	☐ hives, welts ☐ swelling of parts of the body ☐ blistery rashes ☐ pimply rashes	☐ acne ☐ frequent boils ☐ other:

Food Allergies

Check box if not applicable ☐

Food	Reaction noted	When did the reaction occur? (age or date)	Is the food completely avoided?
			☐ yes ☐ no
			☐ yes ☐ no
			☐ yes ☐ no
			☐ yes ☐ no

What medications are you taking? (*list both prescription and non-prescription*)

Name of Drug	Which strength?	Frequency

Your Medical History:

☐ asthma	☐ pacemaker	☐ celiac disease
☐ hay fever	☐ arthritis	☐ cancer (type):
☐ eczema	☐ cholesterol high	☐ chemotherapy
☐ hives	☐ diabetes	☐ attention deficit
☐ food allergies	☐ thyroid low	☐ depressive disorder
☐ high blood pressure	☐ emphysema/COPD	☐ anxiety disorder
☐ atrial fibrillation	☐ GERD/reflux	☐ other not listed (inc surgeries):
☐ MI/cardiac stent	☐ Crohn's/ulcerative colitis	

Smoking History ☐ I currently smoke ☐ I never smoked (*skip other questions*) ☐ N/A because patient is child

Have you smoked at least 100 cigarettes in your entire life? ☐ yes ☐ no
If currently smoking, are you a ☐ everyday smoker ☐ smoke some days only ☐ former smoker, year quit _____

☐ cigarettes #pks./day _____ ☐ pipe - #/day_____ ☐ cigars - #/day_____ ☐ smokeless tobacco - #/day_____
☐ # of years total _____

Family history of allergies? (hay fever, asthma, eczema, food allergies, drugs)

☐ father ☐ mother ☐ brothers or sisters ☐ aunts or uncles ☐ grandparents

Review of Systems

Circle any symptoms that apply to you: **Not applicable** ☐

General: insomnia, tiredness	*Throat*: sore throat, hoarseness, postnasal drip	*Neuro*: anxiety disorder, panic attacks, depression
Eyes: itchy eyes, watery eyes, swollen eyes	*Lungs*: cough, chest tightness, wheezing, shortness of breath	*Joints*: swollen joints
Head: severe or frequent headaches, dizziness	*Chest/heart*: chest pain, palpitations	*Skin*: hives, easy bruising
Ears: ear congestion, decreased hearing, frequent ear infections	*GI*: difficulty swallowing, acid reflux, stomach pain, diarrhea, nausea, vomiting	Other not listed:
Nose: itchy nose, stuffiness, sinus pressure		

Allergies to Medications

Name of drug …	Reaction you had

Environmental Survey

What kind of trees are on your property, if known?

Heating system: ☐ forced air ☐ other

Mold problems? ☐ yes ☐ no

Allergy encasing on mattress? ☐ yes ☐ no

Feather pillow or down comforter? ☐ yes ☐ no

Pets: ☐ no ☐yes (*how many?)* dogs _____ cats _____ other _____

Cigarette smokers inside the house? ☐ yes ☐ no

Any school or workplace exposures you are concerned about?

For office use: