ALLERGY QUESTIONNAIRE

Please carefully complete this questionnaire in full. Accuracy and thoroughness are essential. Print all answers. Relate answers to your own experiences, not to previous results of skin tests. This form must be completed prior to your visit. ALL INFORMATION WILL BE CONSIDERED CONFIDENTIAL.

Patient's Name: _____ Date of Birth: _____

Parent's Name: _____ Telephone No.: _____
(IF CHILD)

Address: _____ _____
(Street) (work)

_____
(City and Zip Code)

Name of referring physician and/or person: _____

Address: _____
(Zip Code)

Telephone No: _____

1. History:
State problem(s) you wish to discuss: _____

_____

_____

When did it begin? _____ (Year) How often does it occur? _____
(times per day, week, etc.)

Worse at night or day? _____ How long does it last? _____
(hours, days, etc.)

Worse indoors or outdoors? _____

Circle months most severe: January February March April May June July August September October November December ALL YEAR

What do you think makes it better? _____

What do you think makes it worse? _____

What do you think causes the problem? _____

Medications presently used to control problem(s) _____

_____ Are they effective? _____

2. Seriousness of problem has caused: absence from work, absence from school, inability to sleep, inability to exercise, loss of appetite, nervousness, other: _____

3. Unusual activities engaged in just prior to onset of symptoms: _____

4. Unusual food or drink just prior to onset of symptoms:
_____

5. New environmental factors at home or at work:
_____

6. Emotional factors: tension, worry, trouble sleeping, financial problems, marital problems, family problems, problems at work, fatigue, cry easily, depression, sexual problems, others: _____
_____

Do any of the above affect your problem? Yes/No
Explain: _____
_____

CIRCLE FACTORS WHICH MAY AFFECT YOUR PROBLEM:

Irritants: cleaner detergent, cooking odor, perfume, powder, tobacco smoke, other smoke: _____, moth balls, motor fumes, paint lacquer, wax, glue, insect spray, fertilizers, ammonia, room deodorants, chemicals, Clorox, other: _____

Toiletries: soap, shampoo, shaving cream, after shave, spray deodorant, hair spray, hair tonic, hair dye, hand cream, make-up, toothpaste, denture cream, mouthwash, nail polish, other: _____

Foods: milk, cheese, eggs, fish, shellfish, nuts, chocolate, alcohol, wine, beer, juices, spices, vegetables, strawberries, wheat products, very cold liquids, other: _____

Pets: Which of these do you have as pets: dog, cat, bird, horse, hamster, rabbit, other: _____ Is your condition worse around pets? Specify: _____

Drugs: Penicillin, Sulfa, Aspirin, Over-the-counter drugs, other: _____

Weather: hot, cold, humid, damp, pollution, sunlight, air-conditioning, change in temperature, rain

New Unwashed Clothing:	wool, silk, sweater, coat, shoes, dry-cleaned clothes, starched clothes, other: _____
Contactants:	poison ivy, cut grass, cut flowers, household plants, hay, plastic, Christmas trees, fiberglass, rubber, dust, wool blankets, mattress, feather pillows, overstuffed furniture, rugs, rug pads, stuffed toys, furs, jewelry, shoe polish, other:_____
Exercise:	running, jumping, swimming, basketball, skiing, tennis, other:_____
Emotions:	crying, laughing, nervousness, happiness, other: _____
Infection:	colds, sinus infection, ear infection, other: _____ _____

CIRCLE SYMPTOMS THAT MAY OCCUR OR BROUGHT ON BY YOUR PROBLEM

General:	nervousness, dizziness, fainting, sinus trouble, frequent colds,fatigue, Other: _____
Headache:	Where (front, back, right, left). Day, night. aching, throbbing, sharp, dull, with vomiting, stuffy nose, better with sleep, worse with tension, spots before eyes. CAUSE: Migraine, food, sinus, tension, drug, other: _____
Skin:	rash, hives, eczema, blisters, itching, swelling, burning, stinging, redness, perspiration, dandruff, athlete's foot Where:_____ Worse after eating? Yes/No
Eyes:	tearing, burning, itching, pain, redness, discharge, puffiness, infections, blurring of vision, glaucoma, other: _____
Ears:	pressure, itchiness, drainage, bleeding, infections, deafness, swelling, other: _____
Nose:	trouble smelling, stuffiness, sniffles, itching, sneezing snoring, polyps, postnasal drip, picking, bleeding, broken nose, previous surgery, other: _____
Tongue:	swollen, sore, itching, coated, trouble tasting, other:_____

Mouth: itching of roof, repeated tonsillitis, tonsils removed, morning sore throat, bad breath, swollen lip, trouble swallowing, mouth breathing, frequent throat clearing, change in voice, other: _____

Mucus: thick, thin, clear, yellow, green, brown, bloody; amount per day: teaspoon, tablespoon, 1/2 cup; Source of mucus: nose, lungs, throat

Chest: shortness of breath, wheeze, pain, tightness, cough, cough then wheeze, trouble walking, trouble working, trouble sleeping, heart trouble, high blood pressure, emphysema, bronchitis, pneumonia, tuberculosis, cancer, other: _____

Stomach: vomiting, heartburn, acid taste in mouth, gas, cramps, belching, diarrhea, mucus in stool, blood in stool, foul-smelling stool, soiling: worse after eating what foods: _____ other: _____

Joints: pain, stiffness, swelling, other: _____

Menses: regular, irregular, discharge, itch, cramps, infections, pain last period: _____ (date) Are you now pregnant? Yes/No Taking birth control pills? Yes/No

Urine: pain, burning, frequent urination, bladder infection, recurrent infection, itching, chills, fever, other: _____

Medication Now Used:	Times Used Per Day:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

PLEASE INDICATE OTHER MEDICATIONS YOU/YOUR CHILD HAVE RECEIVED. (HOW OFTEN AND/OR HOW RECENTLY)

A. Antihistamines (Actifed, Dimetapp, Rondec, Benadryl):

_____

B. Decongestants (Sudafed, Entex):

_____

C. Antibiotics

_____

D. Wheezing medicine (bronchodilators):

_____

E. Steroids (prednisone, decadron):

_____

F. Sprays, mists, nosedrops:

_____

G. Gamma globulin:

_____

H. Others:

_____

ENVIRONMENTAL HISTORY (Circle pertinent items and fill in the blanks)

1. Where do you live? room, apartment, brick house, wood-frame house, mobile home, age of home _____ years.

2. Location: city, suburbs, country, farm, near factory, bakery, swamp, grain storage, poultry yard, barn, other: _____

3. Type of heating: forced air, radiator, electric, heat pump, filtered air, gas, oil, space heater, wood burning stove, other: _____

4. Air conditioning: window unit, central, open window, swamp cooler

5. Do you use a vaporizer or central humidifier? _____

6. Do you have an air cleaner? _____

7. Do you have a basement or attic? _____

8. Your bedroom:
   Carpeting: Yes/No; Type _____ How old _____
   Type of mattress: _____ How old _____
   Type of pillows: _____ How old _____
   Type of blankets/quilts: _____ How old _____
   Type of bedspread: _____ How old _____
   Type of drapes/shades on windows: _____ How old _____
   Are there plastic covers on the mattress? Yes/No
   Are there plastic covers on the pillows? Yes/No
   Are there plants/stuffed animals/upholstered furniture in the bedroom? Yes/No

9. Family members who smoke: _____

10. Animal contacts: Type of animal(s) _____
Inside home: Yes/No; Outside home: Yes/No
How often do you come in contact with these animals? _____

11. Do you live near any areas of heavy smog or air pollution? _____

12. Is mold or mildew (musty odor) a problem in your home? _____

13. Are you exposed to any chemical, organic dust, etc. at home or at work?
_____

14. Problem worse when: at home, bedroom, living room, kitchen, basement, attic, garage, indoors, outdoors, at work, in car, in boat, exercising, at beauty shop, at school, driving in traffic, sweeping, house cleaning, making beds, around fans, around humidifier, around vaporizer, around open windows, around heating ducts, on windy days, taking hot or cold baths, swimming in chlorinated water, in musty places, wearing tight clothing, other: _____

PAST HISTORY

1. Childhood: breast fed, bottle fed, colic, spitting up, gas, croup, hives, eczema, hay fever, frequent colds, migraine, sinus trouble, ear infections, tonsillitis, dizziness, asthma, bronchitis, pleurisy, pneumonia, skin rashes,
other:_____

2. Known allergies:
(a) Medications _____
type of reaction _____

(b) Foods _____
type of reaction _____

(c) Insect bite or sting _____
type of reaction _____

3. Hospitalizations:

Reason	Year

Emergency Room Visits:

_____
_____
_____
_____

4. Previous allergy workup:

Physician	Date	Results

5. IMMUNIZATION: Circle the ones you have received and describe any reactions

	Reaction		Reaction
Diptheria	_____	MMR (Measles, Mumps & Rubella)	_____
Tetanus	_____	Whooping Cough	_____
Polio	_____	Influenza	_____
Chicken Pox	_____	Other	_____

1. List any medical condition(s) for which you have been treated:

_____

2. List any operations you have had: _____

_____

3. List any other conditions for which you are currently being evaluated or treated: _____

_____

_____

4. Do you smoke: _____
   How much: _____
   Have you ever smoked: _____
   When did you start: _____ Stopped: _____

5. Do you drink:
   Wine: _____ How much: ___/day
   Beer: _____ How much: ___/day
   Liquor: _____ How much: ___/day
   Socially only: _____

6. Do you use drugs other than prescribed by a physician:
   (substance abuse)

_____

FAMILY HISTORY: Please check any family member having any of the following conditions in the appropriate box.

Family Illnesses	Father	Mother	Brothers	Sisters	Children	Other Blood Relatives
Asthma (Childhood) (Now)						
Emphysema						
Cystic Fibrosis						
Sinus Problems						
Tuberculosis						
Hay Fever						
Migraine						
Eczema						
Food Allergies						
Drug Allergies						
Thyroid						
Glaucoma						
Other						

HOBBIES:

Husband: _____

Wife: _____

Children: _____

Others at home: _____

THANK YOU FOR YOUR COOPERATION!