Adult & Pediatric Allergy Clinic
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# PATIENT ALLERGY HISTORY QUESTIONNAIRE

Name: DOB: Date:_____

ALLERGY SYMPTOMS *Please check all that apply*

| | | | | |
|---|---|---|---|---|
| □ Itchy nose | □ Nasal congestion | □ Runny nose | □ Postnasal drip | □ Loss of smell |
| □ Itchy eyes | □ Watery eyes | □ Itchy throat | □ Ear infection | □ Dizziness |
| □ Ear popping | □ Ear fullness/pressure | □ Sore throat | □ Cough | □ Wheezing |
| | | □ Itchy skin/rashes/hives | | |

During what months are you symptomatic? *Please circle all that apply*

WINTER SPRING SUMMER FALL YEAR ROUND

When are your symptoms worse? *Please circle* Morning Afternoon Night

Are your symptoms aggravated by any of the following? *Please check all that apply*

| | | |
|---|---|---|
| □ Indoors | □ Mowing the lawn | □ Aspirin |
| □ Outdoors | □ Dusty environment | □ Hair Dye/Perm |
| □ Damp areas | □ Car pollution | □ Perfumes |
| □ Hot weather | □ Animals/Pets | □ Newspapers |
| □ Cold weather | □ Cooking odors | □ Wool |
| □ Dry weather | □ Smoke | □ Cosmetic products |
| □ Windy day | □ Paint Fumes | □ Creams/Lotions |
| □ Weather change | □ Insecticides | □ Alcoholic beverages |
| □ Season change | □ Laundry detergent | □ Beer □ Wine □ Liquor |
| □ Air conditioning | □ Chemicals (list below) | |

_____

_____

PREVIOUS ALLERGY EVALUATION

Have you undergone allergy testing before? Yes ( ) No ( )

If yes, please circle what type of testing you had (Scratch, Intradermal, RAST)

Did you have a positive reaction? Yes ( ) No ( )

Please list what you had a positive reaction to below:

Have you received allergy shots before? Yes ( ) No ( )
If yes, how long were you treated with allergy shots for? _____

Have you had an adverse reaction to allergy injections before? Yes ( ) No ( )

Have you ever been treated in an emergency room for an allergic reaction? Yes ( ) No ( )
If so, please explain_____
_____

ASTHMA HISTORY
Are you currently being treated for asthma? Yes ( ) No ( )
Have you used your rescue inhaler (Proventil, Proair, Ventolin) more than 2 times a week? Yes ( ) No ( )
Have you been awakened because of your asthma symptoms more than 2 times a week? Yes ( ) No ( )
Have you been hospitalized in the last year because of your asthma symptoms? Yes ( ) No ( )

ENVIRONMENT

Occupation:_____ At work, are your symptoms □ Same □ Worse □ Better

Do you smoke? Yes ( ) No ( ) Former Smoker, Quit Date: _____/_____/_____
If you do currently smoke, how much do you smoke a day?_____
Are you exposed to second hand smoke? Yes ( ) No ( )

Does animal/pet exposure make your symptoms worse? Yes ( ) No ( )
Do you have any pets? Yes ( ) No ( )
If yes, please list:_____
Does the pet(s) have full access to the entire house? Yes ( ) No ( )
Does the pet(s) sleep in your bedroom? Yes ( ) No ( )
If yes, where in your bedroom does the pet(s) sleep?_____

| Pillow | Mattress | Comforter | Heating System | Humidifier |
|---|---|---|---|---|
| □ Dacron/Polyester | □ Cotton | □ Chenille | □ Coal | □ Yes |
| □ Feather/Down | □ Feather/Down | □ Cotton | □ Electric | □ No |
| □ Foam rubber | □ Foam rubber | □ Dacron/Polyester | □ Gas | |
| | □ Innerspring | □ Feathers/Down | □ Oil | |
| | □ Other | | □ Other | |

| Method of Heating | Air Conditioning | Floor: | Furniture: | Basement: |
|---|---|---|---|---|
| □ Baseboard | □ Window unit | □ Tile | □ Fabric | □ Finished |
| □ Fireplace | □ Central Air | □ Carpeting | □ Vinyl | □ Unfinished |
| □ Forced air | | □ Area rugs | □ Mohair | □ Damp |
| □ Radiator | | □ Hardwood | □ Other | |
| □ Stove | | □ Wall to wall carpeting | | |