

ALLERGY QUESTIONNAIRE

NAME _____ **DATE** _____

Information provided by this questionnaire will be of **major** assistance in helping you. Please take the time to complete it (takes only 10-15 minutes) before your appointment. Base your answers **on your own observations**.

I. Major Problem

- | | |
|--|--|
| <input type="checkbox"/> Hayfever or "sinus" | <input type="checkbox"/> Insect sting reaction |
| <input type="checkbox"/> Eye problems | <input type="checkbox"/> Drug reaction |
| <input type="checkbox"/> Asthma or chronic cough | <input type="checkbox"/> Intestinal problem |
| <input type="checkbox"/> Hives or swelling | <input type="checkbox"/> Food allergy |
| <input type="checkbox"/> Eczema or other rash | <input type="checkbox"/> Recurrent infections |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Other _____ |

II. Please describe in your own words the problem(s) that you are having which you think might be on a basis of an allergic reaction.

III. Symptom History

A. How long have you had your symptoms? _____

B. Are they getting worse? Yes No

C. Are your symptoms (check one):

- Present all year but worse at certain times of the year?
- Coming and going without apparent relation to the time of the year?
- Only at certain times of the year?

D. Circle the months you are worse: JAN FEB MAR APR MAY JUN JUL AUG SEP OCT NOV DEC

E. Do you have to miss school or work because of allergy symptoms?

- No Occasionally Frequently

F. Do your symptoms disturb your sleep?

No Occasionally Frequently

G. Are you worse (circle): indoors, outdoors, at home, at work, mornings, or evenings

PG 2

IV. Symptom Review (circle all appropriate answers)

A. Eye Symptoms: none, itching, watering, redness, swelling, crusting, dryness, burning, dark circles, blurred vision, wear contact lenses, other _____

B. Ear Symptoms: none, itching, popping, congested, frequent infections, fluid in middle ear, PE tubes, hearing loss, earache, dizziness, other _____

C. Nasal Symptoms: none, sneezing, itching, sniffles, watery discharge, cloudy discharge, congestion, frequent nosebleeds, broken nose, loss of sense of smell/taste, polyps, frequent sinus infections, nasal dryness, snoring at night, other _____

D. Mouth and throat symptoms: none, frequent sore throats, hoarseness, itchy throat, difficulty swallowing, swollen neck glands, mouth breathing, frequent strep throat, frequent tonsillitis, postnasal drip, other _____

E. Headaches: infrequent, occasional, frequent, occur with sinus symptoms, sharp, dull, pounding, facial, forehead, temples, back of head, migraine, other _____

F. Chest symptoms: none, chronic cough, chest tightness/congestion, wheezing, shortness of breath, wheeze/cough after exercise, sputum production, chest pain or soreness _____

Has *asthma* been previously diagnosed? Yes No
 Frequent pneumonias? Yes No
 Abnormal chest x-ray? Yes No have not had chest x-ray
 Other _____ CT Scan? _____ Results? _____.

Stomach/Intestinal symptoms (circle): none, nausea and vomiting, bloating, loss of appetite, abdominal pain or cramping, diarrhea frequently, constipation frequently, pain, or difficulty swallowing, heartburn or indigestion, other _____

H. Skin symptoms: none, dry skin, hives, swelling, itchy skin, eczema, poison ivy/oak allergy, skin sensitivity to metals, chemicals, cosmetics, other _____

I. Insect sting reaction: none, large swelling, hives, difficulty breathing, throat swelling, dizzy, other _____
 Stung by: bee, fire any other insect? _____

V. Allergy Symptom Triggers

Which of the following do you think cause or make your symptoms **worse?** Please check appropriate boxes:

Trigger	Nose/Sinus Eyes/Ears Symptoms	Asthma/ Bronchitis Symptoms	Hives/ Eczema Symptoms	Stomach/ Intestinal Symptoms	Other
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parks/fields				
mowed grass				
gardening				
house dust				
weather changes				
windy days				
humid days				
hot days				
cold days				
air conditioning				
forced air/heat				
drafts				
tobacco smoke				
fumes/aerosols/sprays				
cosmetics/perfumes				
chemicals				
soap powder				
newspaper print				
pets/animal exposure (list _____)				
exercise				
tension/excitement				
clothing/fabrics				
medicines (which)				
milk/dairy products				
beer/wines				
certain foods (list below)				
menstrual periods				
other(s)				

Comments/explanation _____

VI. Treatment

A. List medications you have used to treat allergy symptoms (circle those that were helpful):

B. Side effects from medications: none, drowsiness, irritation or nervousness, insomnia, other

C. Do you use over-the-counter nasal sprays or drops? Yes No

If yes, how often? _____

D. Have you taken cortisone (by injection or mouth) in the past two years? Yes No

E. Have you been on any special allergy diets? Yes No

F. Have you been tested for allergy previously? Yes No

If yes, when and where _____

Did you have positive reactions to: (circle) pollen, dust, animal danders, molds, foods, other _____, or no reactions? _____.

G. Have you been on allergy shots before? Yes No

If yes, when, where, and for how long?

Were they helpful? Yes No Not sure

H. Did you have a serious reaction to allergy testing or allergy shots? Yes No

VII. Past Medical History

A. Have you had an allergic reaction to any medications? Yes No

If yes, please list _____

B. Please list medications (other than allergy medicines) that you take regularly:

C. Previous hospitalizations for allergy problems? Yes No

If yes, please list _____

D. Surgery that you had (circle): none, tonsillectomy, adenoidectomy, nasal septum repair, sinus surgery, tubes in ears, removal of nasal polyps, chest surgery.

E. Infancy—Early childhood problems (circle): none, milk allergy, formula changes, food allergy, colic, frequent diarrhea, frequent constipation, vomiting, frequent skin rashes, bronchiolitis, frequent bronchitis, asthma, eczema.

F. If patient is a child, has growth and development been normal? Yes No

G. Immunizations: severe or unusual reactions? Yes No

VIII. Review of Systems

A. Would you describe your general health as (circle): **EXCELLENT, PRETTY GOOD, GOOD, FAIR, or POOR.**

B. Other medical problems (circle): none, high blood pressure, heart disease, diabetes, emphysema, anemia, liver disease, jaundice, arthritis, intestinal disorders, TB, kidney disease, migraine, epilepsy (seizures), attention deficit disorder, cancer, prostate trouble, thyroid trouble, glaucoma, fatigue, ulcers, sleep difficulty, frequent depression,

C. Psychological Factors

- nervous tension: little considerable
- financial problems: minor major
- work or school adjustment: easy difficult
- marital adjustment: easy difficult

D. Smoking History: Yes No

If yes, amount _____ how long _____

When did you quit? _____

E. Women of childbearing age: Are you pregnant, trying to conceive, or nursing a baby? Yes No

IX. Family History

A. Which family members (including grandparents, aunts, uncles) have hayfever or "sinus" problems?

Which have asthma? _____

Do any family members have (circle): hives or swelling, eczema, food allergy, drug allergy, insect allergy, emphysema, cystic fibrosis, TB diabetes, serious infections, death in infancy.

X. Environmental Survey

A. Residence

1. How long have you lived in Houston, TX? _____

2. Other areas of residence and dates:

3. Do you live in a (circle): house, apartment, mobile home, other _____

Age of home? _____ years How long at present address _____

4. Home located in or near (circle): residential area, open fields, factory, lakes.

5. What type of grasses, trees, and shrubs are in your neighborhood?

6. Is your home air conditioned? Yes No

If yes, central or window? Fans? Yes No

7. Is your home heated? (circle) central, wall, space heaters, fireplace

8. Do you have pets at home? Yes No
(circle) dog, cat, birds, hamsters, other _____

Do the pets spend time indoors? Yes No N/A

In the bedroom? Yes No N/A
List other pets you are exposed to regularly

How long have you had pets? _____

9. Are there smokers at home? Yes No
If yes, how many? _____

10. In patient's bedroom, are there (circle): plants, stuffed toys, carpet, rugs, down comforters, pillows, (feather, foam or synthetic?), drapes, blinds, bookshelves, bunkbeds, humidifiers/vaporizers.

B. Occupation/Hobbies

1. Current occupation: _____
If patient is a child, parents' occupation(s) _____

2. Previous occupation(s): _____

3. Are you exposed to anything at work or school that might aggravate your condition? Yes No
If yes, what

4. Hobbies (circle): sewing, gardening, cooking, painting, sports, photography, other

5. If patient is a child, is he or she in daycare? Yes No. Every day? Yes No

THANK YOU.