ALLERGY QUESTIONNAIRE

379 E. SHORE DR. #100
EAGLE, ID 83616
208-938-3443
INFO@IDAHO-ALLERGY.COM

Name: _____ Age:_____ Date of Birth: _____ Sex: M__ F__

Ethnicity: ( ) Caucasian ( ) Hispanic ( ) Asian ( ) African-American ( ) Other

Your Physician (Name, Address and Phone #): _____

PLEASE ANSWER ALL QUESTIONS TO THE BEST OF YOUR ABILITY. Base your answers on your own observations and not on what others have told you or what you may have assumed on the basis of previous allergy tests. Please complete this form before seeing the allergist as the information will organize your thinking and help us to understand your problem.

What are the problems that bring you to an allergist?

_____

_____

Please indicate the symptoms you experience:

EARS	Yes	No
Itching	( )	( )
Fullness	( )	( )
Popping	( )	( )
Tubes placed	( )	( )
Hard of hearing	( )	( )
Frequent infections	( )	( )
# ear infections/year _____		

NOSE/SINUS	Yes	No
Repeated Sneezing	( )	( )
Watery discharge	( )	( )
Stuffy nose	( )	( )
Itching	( )	( )
Nasal trauma	( )	( )
Bloody nose	( )	( )
Poor sense of smell	( )	( )
Mouth breathing	( )	( )
Bad breath	( )	( )
Snoring	( )	( )

CHEST	Yes	No
Cough	( )	( )
Wheezing	( )	( )
Sputum (phlegm)	( )	( )
Shortness of breath	( )	( )
at rest	( )	( )
with exercising	( )	( )
Coughed up blood	( )	( )
History of bronchitis	( )	( )
History of pneumonia	( )	( )

THROAT	Yes	No
Soreness	( )	( )
Post-Nasal Drip	( )	( )
Itching of Palate	( )	( )
Recurrent Strep infections	( )	( )
Hoarseness	( )	( )
Tonsils	( )	( )
Adenoids removed	( )	( )

EYES	Yes	No
Contact Lenses	( )	( )
Itching	( )	( )
Burning	( )	( )
Watering	( )	( )
Swelling	( )	( )
Redness	( )	( )
Discharge	( )	( )
Glaucoma	( )	( )
Cataract	( )	( )

SKIN	Yes	No
Eczema	( )	( )
Hives	( )	( )
Swelling	( )	( )
Infections (boils, impetigo)	( )	( )
Positive TB skin test	( )	( )

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Names(s) of skin soap(s)/shampoo(s)/moisturizers used? _____

Date of last chest x-ray: _____ Result: _____

Do you have problems wearing LATEX GLOVES or using latex products? (specify) _____

Date of last pulmonary function studies: _____ Result: _____

How many times a year are you treated with antibiotics for nasal/sinus infections? _____

For how long each time? _____

Date of last sinus x-rays? _____ Date of last CT scan of sinuses? _____

Date of any sinus surgery_____

ASTHMA HISTORY

Have you ever been intubated, placed in intensive care, or on a respirator for asthma? _____

# of hospitalizations for asthma: _____ # of emergency room visits for asthma in the last year: _____

Number of courses of oral steroids (Prednisone/Medrol) taken for asthma in the past year: _____

Do you have a peak flow monitor? _____ What is your best peak flow reading: _____

# of times per month awakened with asthma (chest tight/wheeze/cough/short of breath) _____

# of times per week you need to use inhaler for acute asthma (beyond scheduled doses) _____

Is your asthma worse at school or work? _____

SEASONAL INCIDENCE

Please indicate your age when symptoms first appeared and check off the months in which the symptoms occur.

	Age of onset:	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Wheezing	( )	( )	( )	( )	( )	( )	( )	( )	( )	( )	( )	( )	( )
Coughing	( )	( )	( )	( )	( )	( )	( )	( )	( )	( )	( )	( )	( )
Nasal	( )	( )	( )	( )	( )	( )	( )	( )	( )	( )	( )	( )	( )
Eye	( )	( )	( )	( )	( )	( )	( )	( )	( )	( )	( )	( )	( )
Hives	( )	( )	( )	( )	( )	( )	( )	( )	( )	( )	( )	( )	( )
Eczema	( )	( )	( )	( )	( )	( )	( )	( )	( )	( )	( )	( )	( )
Other	( )	( )	( )	( )	( )	( )	( )	( )	( )	( )	( )	( )	( )

Are symptoms worse after exposure to:

( ) Raking leaves	( ) Humidity/heat	( ) Cigarette smoke	( ) Medications
( ) Lawn mowing	( ) Cold air	( ) Perfumes	
( ) Hay/compost	( ) Air conditioning	( ) Strong odors	
( ) Damp basement	( ) Weather changes	( ) Newsprint	
( ) Animals/Pets	( ) Smog (exhaust fumes)	( ) Foods	

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ENVIRONMENT

How long have you lived in Idaho? _____

Prior states(s)? _____

Type of home _____ How old is home? _____ How long lived there? _____

Location of home ( ) Country ( ) Suburb ( ) City

Basement ( ) yes ( ) no What is basement used for? _____

Is basement ( ) dry ( ) damp

Does anyone in home smoke? ( ) yes ( ) no Who?_____ How much?_____

ANIMALS:

Do you have any pets? ( ) yes ( ) no

If yes, please list: _____

How long have the pets been with you? _____

Does the animal have full use of the house? ( ) yes ( ) no

Does the animal sleep on the patient's bed? ( ) yes ( ) no

Does animal exposure make symptoms worse? ( ) yes ( ) no

PATIENT'S BEDROOM:

Mattress

Age: _____ years

Type:

Innerspring cotton ( )
Foam ( )
Other _____

Pillow(s)

Age: _____ years

Type:

Feather ( )
Foam rubber ( )
Synthetic ( )
Buckwheat ( )

INSECT ALLERGY

After a bee sting do you have problems with:

	Yes	No		Yes	No
Local swelling	( )	( )	Hives	( )	( )
Tongue/Lip swelling	( )	( )	Swelling	( )	( )
Scattered hives	( )	( )	Shortness of breath	( )	( )

Have you ever been treated in an Emergency Room for an insect sting? _____ Date: _____

FOOD ALLERGIES/SENSITIVITIES: Do you have problems with any foods? If yes, describe problem. For instance: swelling or itching of tongue, lips, or mouth? Rashes or hives? Immediate or delayed vomiting or diarrhea?

Eggs _____
Wheat _____
Milk _____
Cheese _____
Shellfish _____
Tomatoes _____
Others _____

Fish _____
Melon _____
Bananas _____
Walnuts _____
Peanuts _____
Soy _____

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DRUG ALLERGIES/SENSITIVITIES: Please list all medications to which you have had an adverse reaction and describe that reaction.

Medication Name	Approximate date and description of reaction
	PATIENT

HEALTH HISTORY:	Yes	No		Yes	No
High blood pressure	( )	( )	Diabetes	( )	( )
Heart disease or arrhythmia	( )	( )	Thyroid disease	( )	( )
Blood transfusion	( )	( )	Liver disease	( )	( )
Uncontrolled bleeding	( )	( )	Kidney disease	( )	( )
Dental problems	( )	( )	Arthritis	( )	( )
Cancer	( )	( )	Heartburn	( )	( )
Childhood Chicken Pox	( )	( )	Chronic diarrhea	( )	( )

Other ongoing medical problems? Please list:_____ _____
_____ _____
_____ _____

Surgeries: Please list procedure: Date:

_____ _____
_____ _____
_____ _____

Hospitalizations: Please list reason: Date:

_____ _____
_____ _____
_____ _____

MEDICATIONS: Please list **ALL** medications that you are currently taking, dosage, frequency, and for what condition(s).

Medication name/dosage	*Frequency*	*For what condition(s)*

IMMUNIZATIONS:	Yes	No	Date(s)
Childhood series	( )	( )	
Hepatitis B	( )	( )	
Tetanus	( )	( )	
Pneumovax	( )	( )	
Chicken Pox Vaccine	( )	( )	

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FAMILY HEALTH HISTORY

Does anyone in your family, **other than you**, have asthma, hay fever, hives, eczema? _____

Any other chronic illnesses, (i.e., heart, lung, kidney) or diseases? _____

	Yes	No		Yes	No
Nose & Eye Allergies (hayfever)	( )	( )	Thyroid disease	( )	( )
Food allergies	( )	( )	Rheumatoid arthritis	( )	( )
Stinging insect allergy	( )	( )	Lupus	( )	( )
Asthma	( )	( )	Cystic Fibrosis	( )	( )
Hives	( )	( )	Sarcoidosis	( )	( )
Eczema	( )	( )	Tuberculosis	( )	( )
Drug allergies	( )	( )			

SOCIAL HISTORY

( ) Married ( ) Single ( ) Divorced ( ) Widowed
Occupation of patient: _____
Briefly describe workplace/school environment:
_____
Number of days work/school missed in last year: _____
Does patient consume alcoholic beverages? ( ) yes ( ) no
If yes, type and frequency?_____
Does patient smoke? ( ) Current ( ) Former ( ) Never
If yes, how many packs/day?_____

Please list your hobbies and/or spare time activities:
_____
_____
_____

THIS SECTION TO BE COMPLETED BY PHYSICIAN

R.O.S._____

Eyes _____ Lungs _____

Ears _____ Heart _____

Nose _____ Abdomen _____

Sinus _____ Extremities _____

Oropharynx _____ Skin _____

Neck _____