ALLERGIC DISEASE AND ASTHMA CENTER, P.A.
ALLERGY QUESTIONNAIRE

Please answer all questions. If not applicable, write NA

Name ___________________ Date of birth ___________ Todays’ Date ___________

Why were you referred to our office? _____________________________________________

How did you hear about our practice? _____________________________________________

What are your most bothersome symptoms? __________________________________________

Age when symptoms first occurred: ______ Symptoms are worse in which season? ____________________

PREVIOUS ALLERGY HISTORY

Have you been allergy tested before? ☐ YES ☐ NO If yes, when? ____________________________

Did you receive allergy injections? ☐ YES ☐ NO Why did you stop? ____________________________

Check items that trigger or worsen your symptoms:

☐ Dry, clear weather ☐ Mold ☐ Strong smells ☐ Cosmetics
☐ Wet, rainy weather ☐ Mowing the grass ☐ Being in a draft Exposure to:
☐ Being in the wind ☐ Raking leaves ☐ Tobacco smoke ☐ Dogs
☐ Being outside ☐ House dust ☐ Exercise ☐ Cats
☐ Cold weather ☐ Being in a musty ☐ Eating ☐ Birds
☐ Change in weather ☐ room/basement ☐ Hair sprays ☐ Other____

CURRENT MEDICATION(s) and dose:

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

PAST MEDICAL HISTORY (List all known medical conditions)

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

DRUG ALLERGIES (Please list all drugs you may be allergic to and the reaction that occurs)

Name: __________________________________ Reaction: _____________________________

Name: __________________________________ Reaction: _____________________________

Name: __________________________________ Reaction: _____________________________

FOOD ALLERGIES Have you ever had an allergic reaction to a food? ☐ YES ☐ NO

Food: __________________________________ Reaction: _____________________________

Food: __________________________________ Reaction: _____________________________

Food: __________________________________ Reaction: _____________________________
INSECT ALLERGIES

Insect: __________________________________   Reaction: ____________________________________________
Insect: __________________________________   Reaction: ____________________________________________
Insect: __________________________________   Reaction: ____________________________________________

Do you carry epinephrine?  □ YES □ NO

SURGICAL HISTORY (List surgeries and dates):

________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

HOSPITALIZATION(s) (list date and reason)

________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

FAMILY MEDICAL HISTORY

<table>
<thead>
<tr>
<th>State age of</th>
<th>Father:</th>
<th>Mother:</th>
<th>Sisters:</th>
<th>Brothers:</th>
<th>Children:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Father:</td>
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<tr>
<td>Mother:</td>
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<tr>
<td>Sisters:</td>
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<tr>
<td>Brothers:</td>
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<td>Children:</td>
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</tbody>
</table>

List illnesses which run in your family: (arthritis, diabetes, heart disease, emphysema, migraines, etc.)

________________________________________________________________________________________

SOCIAL HISTORY

Education: ____________________________ Occupation: ____________________________
Birthplace: __________________________ Marital Status: __________________________
Hobbies: ______________________________

TOBACCO AND ALCOHOL USAGE:

Do you smoke cigarettes?  □ Yes □ No  If yes, how many per day? __________________
How long after waking do you smoke? _____ minutes _____ hours. Are you interested in quitting? □ YES □ NO
Are you a former smoker? □ Yes □ No  If yes, when did you quit? __________________
Do you use smokeless tobacco? □ YES □ NO  If yes, what type? ______________________
Do you drink alcohol? □ Yes □ No  If yes, how many drinks containing alcohol do you consume per week? ______

ENVIRONMENTAL HISTORY

State age of your home: ______ years. How long have you lived there? ____________________________
What type of floor covering do you have? □ Carpet □ Wood □ Vinyl □ Tile
Type of cooling system □ Central cooling □ Window unit □ other ____________________________
Type of heating system □ Gas □ Electric □ other ____________________________
Do you have any pets?  □ Yes  □ No  If so, list pets:__________________________________________________________

Is there mold present in your home?  □ Yes  □ No

What type of pillow do you use?  □ Foam  □ Feather  □ Cotton  □ Fiberfill  □ Temperpedic

Check those symptoms that you are having or have had:

<table>
<thead>
<tr>
<th>GENERAL</th>
<th>NOW</th>
<th>PAST</th>
<th>RESPIRATORY</th>
<th>NOW</th>
<th>PAST</th>
</tr>
</thead>
<tbody>
<tr>
<td>Change of appetite</td>
<td></td>
<td></td>
<td>Cough</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Weight Change</td>
<td></td>
<td></td>
<td>Chest pain</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fatigue</td>
<td></td>
<td></td>
<td>Shortness of breath at rest</td>
<td></td>
<td></td>
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<tr>
<td>Fever</td>
<td></td>
<td></td>
<td>Shortness of breath when active</td>
<td></td>
<td></td>
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<tr>
<td>Headache</td>
<td></td>
<td></td>
<td>Pain with inspiration</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lightheadedness</td>
<td></td>
<td></td>
<td>Sputum production</td>
<td></td>
<td></td>
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<tr>
<td>Pain, on a scale of 1-10</td>
<td></td>
<td></td>
<td>Wheezing</td>
<td></td>
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<tr>
<td>Location:</td>
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<table>
<thead>
<tr>
<th>Allergy/Immunology</th>
<th>GASTROINTESTINAL</th>
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<tbody>
<tr>
<td>Watery eyes</td>
<td>Abdominal pain</td>
</tr>
<tr>
<td>Hives</td>
<td>Heartburn</td>
</tr>
<tr>
<td>Itching</td>
<td>Nausea</td>
</tr>
<tr>
<td>Rash</td>
<td>Vomiting</td>
</tr>
<tr>
<td>Sneezing</td>
<td>Diarrhea</td>
</tr>
<tr>
<td>Congestion</td>
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</table>

<table>
<thead>
<tr>
<th>EAR/NOSE/THROAT</th>
<th>SKIN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Decreased hearing</td>
<td>Itching</td>
</tr>
<tr>
<td>Ear Pressure</td>
<td>Rash</td>
</tr>
<tr>
<td>Ear pain</td>
<td>Dry skin</td>
</tr>
<tr>
<td>Nosebleeds</td>
<td>Eczema</td>
</tr>
<tr>
<td>Sinus pain</td>
<td>Hives</td>
</tr>
<tr>
<td>Post-nasal drainage</td>
<td>Swelling/angioedema</td>
</tr>
<tr>
<td>Sore throat</td>
<td></td>
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<tr>
<td>Swollen glands</td>
<td>Other symptoms: (please write)</td>
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<table>
<thead>
<tr>
<th>EYES/OPHTHALMOLOGIC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Itching/redness</td>
</tr>
<tr>
<td>Swelling</td>
</tr>
<tr>
<td>Discharge</td>
</tr>
<tr>
<td>Dry eye</td>
</tr>
<tr>
<td>Pain</td>
</tr>
</tbody>
</table>

FOR FEMALES ONLY

Are you pregnant or nursing a baby?  Do you have menstrual problems?  □ Yes  □ No

Are you planning a pregnancy anytime soon?  □ Yes  □ No
HIVES or SWELLING (If applicable)

Have you ever experienced hives / welts / swelling? __________________________ (If NO, move to next section)
When did the hives or swelling first occur? ________________________________
Are your hives or swelling becoming worse or occurring more often? ________________________________
What do you suspect is the cause? ___________________________________________
What size are the individual hive lesions? _________________________________________
Please describe the swelling: _________________________________________________
When you break out in hives, or have swelling, how long does it last? ________________
Where on your body do hives break out most often? _______________________________
Where does the swelling occur on your body? _____________________________________
Does anything provide relief? _________________________________________________

FOR CHILDREN ONLY

Does your child stay in a nursery or daycare center? □ Yes □ No
Does your child have a history of eczema? □ Yes □ No
Were there any complications during pregnancy? □ Yes □ No
What was the birth weight? _________________________________________________
Did the baby have trouble breathing shortly after birth? □ Yes □ No

FOOD HISTORY:
Was the child breast or bottle fed? ____________________________________________
Are all foods tolerated? □ Yes □ No
Is there coughing during or following feedings? □ Yes □ No
Are Immunizations up to date? □ Yes □ No

Have you received your pneumonia vaccine? (for adults 65 and older) □ Yes □ No Date received: ____________
When was the last time you received a Flu vaccine: _______________________________

NOTE: Information in this questionnaire is a confidential part of your medical record and will only be released with your written authorization.

Signature of person completing questionnaire: _______________________________________

Date: ___________________________