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

State age of	Father:	Mother:	Sisters:	Brothers:	Children:
Do they have:					
Hay fever					
Asthma					
Hives					
Eczema					
Sinusitis					

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 <u>having</u> or <u>have</u> had:

GENERAL	NOW	PAST	RESPIRATORY	NOW	PAST
Change of appetite			Cough		
Weight Change			Chest pain		
Fatigue			Shortness of breath at rest		
Fever			Shortness of breath when active		
Headache			Pain with inspiration		
Lightheadedness			Sputum production		
Pain, on a scale of 1-10			Wheezing		
Location:					
Allergy/Immunology			**GASTROINTESTINAL**		
Watery eyes			Abdominal pain		
Hives			Heartburn		
Itching			Nausea		
Rash			Vomiting		
Sneezing			Diarrhea		
Congestion					
EAR/NOSE/THROAT			**SKIN**		
Decreased hearing			Itching		
Ear Pressure			Rash		
Ear pain			Dry skin		
Nosebleeds			Eczema		
Sinus pain			Hives		
Post-nasal drainage			Swelling/angioedema		
Sore throat					
Swollen glands			**Other symptoms:** (please write)		
EYES/OPHTHALMOLOGIC					
Itching/redness					
Swelling					
Discharge					
Dry eye					
Pain					

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: _____