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# ALLERGY QUESTIONNAIRE

Please answer all questions. If you do not understand the question, insert a question mark. There are 6 pages. Please fill out all pages to the best of your ability.

Patient Name:_______________________________________________ Date:____________________

Address:_______________________________________________________________________________

Date of Birth:____________________________Referred by:____________________________________

Number of years in California:____________ Occupation:____________________________________

Other Cities of Residence and Dates:___________________________________________________

If patient is a child: Father: Age: ______ Occupation:_______________ Hobbies:______________

Mother: Age: ______ Occupation:_______________ Hobbies:______________

**A. <u>MAJOR REASON FOR REFERRAL:</u>** (Please check appropriate brackets)

1. [ ] Hayfever [ ] Bronchitis [ ] Hives [ ] Insect Reaction
   [ ] Sinus [ ] Ear Problems [ ] Eczema [ ] Recurrent Infection
   [ ] Asthma [ ] Eye Problems [ ] Drug Reaction [ ] Intestinal Problems
   [ ] Other ____________________________________________________________

2. In your own words detail your most distressing allergy symptoms. Be complete as to how long symptoms have been present, how severe, and if you suspect agents that trigger symptoms.
   ________________________________________________________________________
   ________________________________________________________________________
   ________________________________________________________________________

**B. <u>MEDICATIONS FOR ALLERGY:</u>**

1. <u>List all current medications</u> (include aspirin, nose drops, cold preparations, vitamins, etc.)

| | A | B | C | D | E |
|---|---|---|---|---|---|
| Medication Name | | | | | |
| Dose | | | | | |
| Frequency per Day | | | | | |
| Does It Help? | | | | | |
| Side Effects | | | | | |

2. List other current medications for other diseases ____________________________________

3. Do you use nasal sprays or drops? Yes____ No____. If yes; how often per day ____? How long? ____ days, weeks, month.

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4. Have you had allergy shots before? Yes____ No____. If yes how long?___________________
5. Food Elimination_________________________________________________________________
6. Behavior modification____________________________________________________________

**C. <u>INFANCY AND CHILDHOOD:</u>** (Please check appropriate boxes)

1. ☐ Milk Allergy ☐ Colic ☐ Diarrhea ☐ Vomiting ☐ Skin Rashes
2. Immunizations:
   ☐ DPT ☐ Oral Polio ☐ Measles ☐ German Measles ☐ Mumps ☐ Smallpox

   Any unusual reactions to these vaccinations?__________________________________________
3. Childhood Illnesses:
   ☐ Measles ☐ German Measles ☐ Mumps ☐ Chicken Pox ☐ Roseola ☐ Croup
   ☐ Whooping Cough ☐ Asthma ☐ Eczema ☐ Hayfever

**D. <u>MEDICAL HISTORY:</u>**

1. General Health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor
2. Weight in past year: ☐ Stable ☐ Gain ☐ Loss – Amount ___________________
3. Hospitalizations:

| | Hospital Name | Year | Reason | Treatment |
|---|---|---|---|---|
| a. | ______________________ | _________ | _______________________ | ________________________ |
| b. | ______________________ | _________ | _______________________ | ________________________ |
| c. | ______________________ | _________ | _______________________ | ________________________ |

4. Do you smoke? ______________ How much? _______________ When did you quit?___________
5. Other medical problems: _____________________________________________________________

   _____________________________________________________________________________________

**E. <u>PSYCHOSOCIAL:</u>**

1. Marital/family adjustment ____________________________________________________________
2. Alcohol or chemical dependency _______________________________________________________
3. Work/School adjustment ______________________________________________________________
4. Financial problems __________________________________________________________________
5. Tendency to worry/anxiety/panic_______________________________________________________
6. Tendency to depression ______________________________________________________________

**F. <u>SURGICAL PROCEDURES:</u>** (Please check appropriate boxes)

☐ Tonsillectomy ☐ Adenoidectomy ☐ Nasal Septum Repair ☐ Sinus Surgery
☐ Chest Surgery ☐ Tubes in Ear ☐ Removal of Nasal Polyps

**G. REVIEW OF SYSTEMS:**

CHECK only those items (1-25) that apply to your condition and circle the appropriate words following the item, if item does not apply leave blank.

1. ☐ FREQUENT HEADACHE: Related nasal symptoms. Frontal, sides, back, relief with aspirin Y/N?
2. ☐ EAR PROBLEMS: Mild, moderate, severe, improving, same, worse, itch, drainage, blockage, popping, frequent infections, hearing loss, fluid in middle ear, ruptured ear drum ___________
3. ☐ EYE PROBLEMS: Mild, moderate, severe, improving, same, worse, red, itch, tear, swell, painful discharge, crusting, change in vision ______________________________.
4. ☐ NASAL PROBLEMS: Mild, moderate, severe, improving, same worse. Sneeze, itch, sniffles, watery discharge, blocked, sinus infections, snores, nose bleed, post nasal drip, polyps, broken nose, loss of sense of smell, nasal or sinus surgery ___________________________.
5. ☐ MOUTH AND THROAT: Soreness, frequent throat clearing, frequent tonsillitis, itchy throat, hoarse, cold sores, swollen neck glands, difficulty swallowing.
6. ☐ ASTHMA: Mild, moderate, severe. Improving, same, worse. Wheeze some, almost everyday, cough, phlegm, chest congestion, pain, difficulty breathing. Attacks per month (average) __________ Emergency visits in past year____________________. Days of work or school missed per month (average) _____________________________.
7. ☐ HOSPITALIZATIONS FOR ASTHMA: List dates and hospital ______________________________
8. ☐ BRONCHIAL INFECTION AS INFANT: Croup, bronchiolitis, bronchitis ______________________
9. ☐ PNEUMONIA: List dates and hospital _______________________________________________
10. ☐ CHEST X-RAY: Dates & results _____________________________________________________
11. ☐ CAT-SCAN SINUSES: Dates & results _______________________________________________
12. ☐ CHOKING SPELL: Peanut, popcorn, other (list) _____________________________________
13. ☐ FREQUENT CHOKING OR VOMITING: ______________________________________________
14. ☐ POSITIVE TEST FOR TB, VALLEY FEVER ______________________________________________
15. ☐ CHRONIC COUGH: Daily, more than 3 months per year, clear phlegm, colored phlegm, dry blood, brown or black specks, daytime, nighttime. How many years? __________
16. ☐ CHEST PAIN: ____________________________________________________________________
17. ☐ HOW MANY "COLDS" OR "FLU" illnesses have you had in the last year? #___________ and in the last 5 years, #______________. How many of these are complicated by: OTITIS-earache, block ____________%. SINUSITIS-pressure, colored drainage _____________%. BRONCHITIS- COUGH WITH COLORED PHLEGM __________%. Asthma-chest tightness, wheezing ____________%. Which antibiotics work best for you? ________________________.
18. ☐ SLEEP DISRUPTION OR FATIGUE?_____________________________________________________
19. ☐ STOMACH OR INTESTINAL PROBLEMS: Difficulty swallowing, loss of appetite, nausea, vomiting, diarrhea, ulcers, abdominal pain, black or blood bowel movement, abnormal bowel movement, heartburn, ___________________________________________________________
20. ☐ ECZEMA, HIVES, OR SWELLING: Aggravating factors, sun, cold, physical activity, nerves, foods ________________________________________________________________________________
21. ☐ OTHER SKIN PROBLEMS: Dryness, itch with rash, easy bruising, small bumpy rash __________
22. ☐ INSECT ALLERGY: Bee, yellow jacket, hornet, wasp, other _____________________________ Type of reaction __________________________________Last reaction___________________ Describe _________________________________________________________________________
23. ☐ FOOD ALLERGIES: Milk, eggs, wheat, fish, chocolate, peanuts, other nuts, orange, tomato, other________________ Last reaction ____________ Describe ___________________________
24. ☐ DRUG ALLERGIES: Aspirin, penicillin, sulfa, x-ray dyes, novocaine, other __________________ When was last reaction? ________________ Describe ___________________________________
25. ☐ LATEX ALLERGY: ____y/n? When was last reaction?________ Describe ___________________

# ALLERGY QUESTIONNAIRE

CHECK appropriate box for symptoms aggravated or precipitated by exposure:

| | EYES | NOSE SINUSES EARS | CHEST | DIGESTIVE | HIVES SWELLING | ECZEMA |
|---|---|---|---|---|---|---|
| Spring (March-April-May) | | | | | | |
| Summer (June-July-August) | | | | | | |
| Autumn (Sept-Oct-Nov) | | | | | | |
| Winter (Dec-Jan-Feb) | | | | | | |
| Sleep | | | | | | |
| On Awakening | | | | | | |
| At Work | | | | | | |
| At Play | | | | | | |
| Indoors vs. Outdoors | | | | | | |
| Vacation/Travel out of area | | | | | | |
| Exercise | | | | | | |
| Emotional Upset | | | | | | |
| Weather Changes | | | | | | |
| Dampness | | | | | | |
| Heat | | | | | | |
| Cold | | | | | | |
| Air Conditioning | | | | | | |
| Sunlight | | | | | | |
| Irritant Fumes/Aerosols/Spray | | | | | | |
| Smog | | | | | | |
| Cosmetics/Perfumes | | | | | | |
| Poison Ivy/Oak | | | | | | |
| Clothing ______________ | | | | | | |
| Tobacco Smoke | | | | | | |
| Newsprint | | | | | | |
| House Dust | | | | | | |
| Road Dust | | | | | | |
| Cats | | | | | | |
| Dogs | | | | | | |
| Birds/Feathers | | | | | | |
| Horses | | | | | | |
| Other Animals ____________ | | | | | | |
| Egg | | | | | | |
| Milk/Dairy Products | | | | | | |
| Beer | | | | | | |
| Wine | | | | | | |
| Wheat Cereals/Wheat Products | | | | | | |
| Corn | | | | | | |
| Chocolate | | | | | | |
| Berries-Strawberries | | | | | | |
| Nut-Peanut/Other ____________ | | | | | | |
| Seafood-Shrimp/Lobster | | | | | | |
| Fish | | | | | | |
| Beef | | | | | | |
| Other Food(s) _______________ | | | | | | |
| Dried Fruits | | | | | | |
| Restaurant Meals | | | | | | |
| Menstrual Cycle | | | | | | |
| Latex Gloves | | | | | | |

# ALLERGY QUESTIONNAIRE

**H. OTHER MEDICAL PROBLEMS:** (Please check appropriate boxes)

| | | | |
|---|---|---|---|
| † High Blood Pressure | † Transfusions | † Cancer | † Bladder/Kidney Infections |
| † Heart Disease | † Tuberculosis | † Fainting Spells | † Other Kidney Disease |
| † Angina | † Jaundice | † Irritable | † Kidney Stones |
| † Diabetes | † Liver Disease | † Fatigue | † Gall Stones |
| † Anemia | † Arthritis | † Sleep Difficulty | † Convulsions or Epilepsy |
| † Frequent Depression | † Glaucoma | † Thyroid Trouble | † Prostate Trouble |

**I. FAMILY HISTORY:** Did anyone in your family ever have any of the numbered conditions listed below? Indicate number(s) on the line to the right of the appropriate blood relation.

Patient’s Mother ___________________________________

Patients Father ____________________________________

Patient’s Brother ___________________________________

Patient’s Sister ____________________________________

Patient’s Maternal Grandparents ______________________

Patient’s Maternal Aunts and Uncles ___________________

Patient’s Paternal Grandparents _______________________

Patient’s Paternal Aunts and Uncles ____________________

1. Hayfever
2. Sinus
3. Asthma
4. Hives or Swelling
5. Eczema
6. Food Allergy
7. Drug Allergy
8. Insect Allergy
9. Emphysema
10. Tuberculosis
11. Diabetes
12. Serious Infection
13. Death in First 2 years of life

**J. ENVIRONMENT:** (Please circle appropriately)

1.) House, Apartment 2.) How long at present address __________. 3.) How old ______________.
4.) Basement 5.) Crawl space 6.) Mildew 7.) Water damage inside 8.) If patient is child where is most of the day spent? ____________________________________________________________

9.) Check any of the following animals at home and fill in how long you have had them.

| | INDOORS | OUTDOORS | | INDOORS | OUTDOORS |
|---|---|---|---|---|---|
| Cat______________ | † | † | Hamsters_______________ | † | † |
| Dog______________ | † | † | Mice/Rats_______________ | † | † |
| Rabbit____________ | † | † | Parakeets_______________ | † | † |
| Horse_____________ | † | † | Pigeons_________________ | † | † |
| Guinea Pig_________ | † | † | Other (list)______________ | † | † |

10.) List any other animals that patient is exposed to regularly:________________________________

11.) Does anyone smoke at home?_________________________________________________________

12.) In bedroom does patient have any of the following? (Please check when appropriate)

† Stuffed toys † Stuffed furniture † Potted Plants † Pets sleep in bedroom
† Radiator † Wall furnace † Floor furnace † Forced air
How often is filter changes?____________________________________________________
† Room air conditioning † Evaporative Cooler † Central air conditioning
† Air purifier † Vaporizer
† Wall to wall carpet † Area rug material _________________________________________

† Curtains/Drapes † Shutters † Blinds † Bookshelves
List other furniture in bedroom ______________________________________________

† Quilt/Chenille bedspread † Down Comforter † Down sleeping bag † Polyester

† Pillows? † Dacron † Feather † Kapok † Foam † Rubber † Wool Blankets

† Box spring and mattress Age?__________ † Plastic covered mattress

† Bunk Beds † Foam Mattress † Waterbed

Frequency of cleaning/vacuuming ______________________________________________

13.) Neighborhood: † Factories † Dairies † Barns † Stables † Near Freeway † Empty Lots

14.) What trees are in your neighborhood? ______________________________________________

15.) Work exposure: † Chemical Fumes † Large amounts of dust † Mold or Mildew

16.) Any significant past exposure to chemical fumes: __________yes ___________none

**K. ALLERGY TREATMENT:**

1. If tested before please check appropriate items:

   Positive to: † grasses † weeds † trees † dust † animals † mold † foods

   † negative tests

2. Allergy shots: _____________No ______________Yes

   If yes Dr.'s name: ______________________________________________

   Dates of shots: From _______________ To ________________ How often ____________________

   Did it help? ____None ____Some improvement ____Much improvement

   Serious reactions to testing or treatment: _________________Yes ______________________No

3. Has patient ever received Cortisone-like drugs (Prednisone, decadron, steroids)?
   ______________________________________________

   When was last dose received? ______________________________________________

______________________________________________ ______________________________
Patient Signature Date

# ALLERGY QUESTIONNAIRE

PHYSICAL EXAMINATION: To be completed by physician.

Ht. Wt. BP Temp General Appearance

SINUSES:

Ears: ______________________________________

Eyes – Lids: _________________________________

Conjunctivae:___________________________

Fundi:_______________________________

Shiners:________________________

Nose:_______________________________________

Crease:______________________________

Polyps:______________________________

Pharynx:____________________________________

T & A:______________________________

Nodes:_____________________________________

Thyroid:____________________________________

Thorax:_____________________________________

PA Diameter:__________________________

Character: ____________________________

Lungs: _____________________________________

Cardiac: ____________________________________

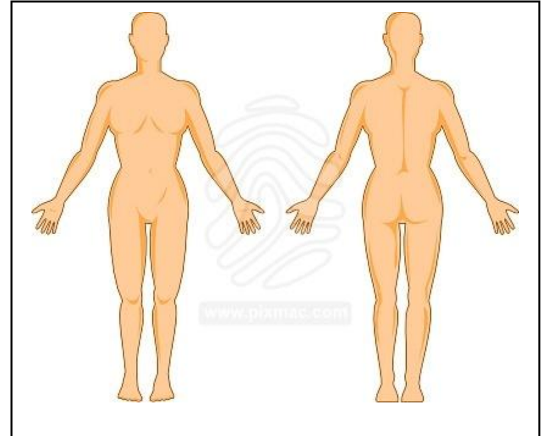
Abdomen: __________________________________

Genitalia: ___________________________________

Neurological/Reflexes: _________________________

Extremities: _________________________________

SKIN:



**DIAGNOSIS:**

**PLAN:**

**SIG:**