Steven F. Weinstein, M.D., FAAAAI, FACAAI Diplomate, American Board of Allergy and Immunology

ALLERGY QUESTIONNAIRE

Introduction: This questionnaire is designed to help us evaluate your allergic symptoms. Please fill out the questionnaire completely. Basically, it asks what your symptoms are, how long you've had them, how much they bother you and what has been done in the past to treat them. It is also necessary for us to know your past medical history and family history. There is space for you to add anything else that may be helpful. If you have questions about how to fill out this questionnaire, feel free to ask any member of our staff for help.

DATE:						
NAME:						
	OF BIRTH:/	AGE:				
OCCUPATION (or grade):						
REFER	RED BY:					
Why are y	ou having (or referred for) an allergy ev	aluation now and not last year?				
Check the	e ones that apply:					
□Nose	□No symptoms How long have you h	ad symptoms				
	- · ·					
	□Nasal symptoms worsening	□Itchy nose				
	□Postnasal drainage (drip in throat)	□Sneezing				
	□Mouth Breather	□Decreased or no sense of smell				
	□Stuffy	□Nose bleeds				
	□Snore	□Runny (□Clear □Discolored)				
	How often do symptoms occur?					
	□Daily □2-3x a week □Weekly	□Monthly □No symptoms				
□Eyes □N	lo symptoms					
	□Itch □Dry eyes □Watery/Tear	ng □Puffy/Swollen □Red □Dark circles				
□Ears □N	lo symptoms					
	□Fullness □Popping □Itch	□Tubes in ears; Date:				
	Number of ear infections in the last ye	ar				
□Throat	□No symptoms					
	□Frequent throat clearing □Sore t	nroat □Frequent throat infections				
	□ Hoarse Voice □ Tonsil	or adenoid surgery				

□Chest	□No symp	otoms								
	□Chest sy	mptoms worser	ning	□Sputum (□	Clear Discolo	red)				
	□Chest tig	htness		□Wh	neezing					
	□Diagnosed with (□Asthma □COPD) □Cough									
	How often do symptoms occur?									
	•	-3x a week □W	•	□Monthly	□No symptom	S				
	Only when sick with Upper Respiratory Infection									
	Do chest symptoms resolve with the use of rescue medication (albuterol): □Yes □No Have you had a Pulmonary Function Test or Spirometry in the last 2 years: □Yes □No Have you been to the Emergency Room or hospitalized on recurrent steroids due to asthma or other breathing problems? □Yes □No									
	Dates:									
	Treatment	:								
Check the on	es that ap	ply: Quality of	life impairn	nent						
Awakening du	e to	□Nightly	□2-3x/wee	k □Once/w	eekly □Monthly	⁄ □Never				
allergic sympto										
Used Kleenex		□ Few sheets		□½ - 1 Box □2 or more boxes						
Exercise induc		□ Cough	□ Wheeze	5						
Do symptoms		□Fatigue	□Anxiety	·		ry umtability				
# of school da	ys missed _l	per year (becau	se of allergi	c symptoms						
# of workdays	missed pe	r year (because	of allergic	symptoms:						
# of physician	visits for al	lergy symptoms	s in the past	year:						
# of nasal sym	ptom free	days per week:		# of chest s	ymptoms free da	ys per week:				
Condition is v	worse whe	n exposed to (check all tl	hat apply):		, 				
□Cats □Smol	ke □S	anta Ana winds	s □Sprino	g □Nig	ht					
□Dogs □Smo	g 🗆 C	Cold Air	□Summ	ner □Day	1					
□Dust □Perfu	ıme □F	all	□Indoo	rs □Cha	ange in weather					
□Grass	□Odors	□Fogs	□Winte	r □Out	doors					
□Other (pleas	e specify):_									
List ALL medi	cations tha	t you are TAKIN	IG NOW?							
MEDICA	TION	# OF TIMES	S A DAY	FIRST P	RESCRIBED	FOR WHAT CONDITION				

What medications have you taken in the **PAST** for your allergies or asthma?

MEDICATION # OF TIMES A DAY FIRST PRESCRIBED

	ATION	<i>"</i> 0	IMES A DAY	FIRST PRESCRI	DLD		CTIVE? (Y/N)	
Previous Tre	atment:							
Have you see		•						
Date seen:								
Results of alle	ergy testing	(what are	you allergic to): _					
Did you receive allergy injections (shots): □ Yes □ No Any reactions to the injections?								
When was the last injection? Did the allergy injections help? □ Yes □ No								
•			hroat Surgeon?					
Date Seen:								
		_						
	Vas it effective? Yes No No Vhen was your last sinus infection?							
Did the sinus	infection re	solve?	Yes 🗆 No					
How many sir	nus infectior	ns do you (get in a year?					
•		-		s within the last year				
Drug Reaction								
Drug	Reaction type Date occurred Onset of re		Onset of read	ction Length		gth of reaction		
Aspirin								
Penicillin								
Sulfa								
Other:								
Food Reactions: □ None								
Food Reaction type Date occurred			Onset of reaction	et of reaction Reaction duration No		Now tolerable?		
Milk								
Eggs								
Restaurant m	eal							
Alcohol								
Other					l			

Female Reproductive Environmental Surversion How long have you live	ey:	Surgically sterile Contracept	on \Box A		hern California	
•		Surgically sterile □ Contracept	on \Box A	Abstinence		
	•	•				
Please list all previ	ious hospit	alizations and operations:	one		Date:	
Please list all other	r illnesses (Past and Present): None			Date:	
Titormal Developmen		Daycare				
Normal Developmer	nt .	Daycare Daycare		Colic		
Diarrhea Eczema		Vomiting Immunizations up to date		Spitting Colic		
Nursed		Formula changes				
		Complications with pregnance	• • •			

Social History: Smoking/Vaping(circle):packs/day foryears. Date quit: □ Not applicable					
Alcohol: # of drinks per dayweekmonth_ Not applicable					
Hobbies: What do you do other than work or school?:					

REVIEW OF SYSTEMS

If not listed above, please check if you've had the following:

General Fever Chills Weight losslbs. Weight gainlbs. Night sweats Fatigue Weakness	Psychology Depression Anxiety/Panic Attacks Insomnia or Disturbed sleep Wake up unrefreshed High stress level Related to allergy?	Neurologic □ Migraines □ Headaches □ Numbness/tingling □ Muscle weakness □ Seizures □ Difficulty thinking or remembering
Ears Hearing loss Swollen ear Ringing in ears Drainage from ear Vertigo	Skin Hair loss Psoriasis Nail problems Dry skin Eczema	Gl/Abdomen □ Abdominal pain □ Difficulty swallowing □ Heartburn □ Acid reflux
Endocrine Cold intolerance Heat intolerance Flushing Diabetes Thyroid High Low	Genitourinary/Urology □ Difficulty urinating □ Cloudy urine □ Blood in urine □ Urinary tract infections	Mouth □ Sores in mouth □ Dry mouth □ Dental problems □ Loss of taste □ Bleeding gums □ Sore throat
Heart Chest pain Irregular/ rapid heart rate Lightheadedness/ passing out Leg/ankle swelling Leg cramps	Blood/Lymph Swollen lymph nodes Blood clots Bleeding tendency Bruising	Scalp/Head Hair loss Scalp tenderness Jaw pain while chewing