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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:
DATE OF BIRTH: _____/_____/_____ AGE: _____
OCCUPATION (or grade):
REFERRED BY:

Why are you having (or referred for) an allergy evaluation now and not last year?

_____

_____

Check the ones that apply:

□**Nose** □No symptoms How long have you had 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** □No symptoms

□Itch □Dry eyes □Watery/Tearing □Puffy/Swollen □Red □Dark circles

□**Ears** □No symptoms

□Fullness □Popping □Itch □Tubes in ears; Date:_____

Number of ear infections in the last year_____.

□**Throat** □No symptoms

□Frequent throat clearing □Sore throat □Frequent throat infections
□Hoarse Voice □Tonsil or adenoid surgery

□**Chest** □No symptoms

□Chest symptoms worsening □Sputum (□Clear □Discolored)

□Chest tightness □Wheezing

□Diagnosed with (□Asthma □COPD) □Cough

How often do symptoms occur?

□Daily □2-3x a week □Weekly □Monthly □No symptoms

□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 ones that apply: Quality of life impairment

Awakening due to allergic symptoms: □Nightly □2-3x/week □Once/weekly □Monthly □Never

Used Kleenex per day: □Few sheets □¼ Box □½ - 1 Box □2 or more boxes

Exercise induced: □Cough □Wheeze □Chest tightness □Shortness of breath

Do symptoms cause: □Fatigue □Anxiety □Depression □Worry □Irritability

# of school days missed per year (because of allergic symptoms: ☐

# of workdays missed per year (because of allergic symptoms: ☐

# of physician visits for allergy symptoms in the past year: ☐

# of nasal symptom free days per week: ☐ # of chest symptoms free days per week: ☐

Condition is worse when exposed to (check all that apply):

□Cats □Smoke □Santa Ana winds □Spring □Night

□Dogs □Smog □Cold Air □Summer □Day

□Dust □Perfume □Fall □Indoors □Change in weather

□Grass □Odors □Fogs □Winter □Outdoors

□Other (please specify):_____

List **ALL** medications that you are **TAKING NOW**?

MEDICATION	# OF TIMES A DAY	FIRST PRESCRIBED	FOR WHAT CONDITION

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

MEDICATION	# OF TIMES A DAY	FIRST PRESCRIBED	EFFECTIVE? (Y/N)

Previous Treatment:

Have you seen another allergist?

Name: _____

Date seen: _____

Results of allergy 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

Have you seen an Ear, Nose and Throat Surgeon?

Name: _____

Date Seen: _____

Previous Ear, Nose or Sinus Surgery (if applicable): _____

Was it effective? □ Yes □ No

When was your last sinus infection? _____

Did the sinus infection resolve? □ Yes □ No

How many sinus infections do you get in a year? _____

Have you had a sinus X-ray or CT scan of the sinuses within the last year? □ Yes □ No

If so, when _____ Findings? _____

Drug Reactions: □ None

Drug	Reaction type	Date occurred	Onset of reaction	Length of reaction
Aspirin				
Penicillin				
Sulfa				
Other:				

Food Reactions: □ None

Food	Reaction type	Date occurred	Onset of reaction	Reaction duration	Now tolerable?
Milk					
Eggs					
Restaurant meal					
Alcohol					
Other					

Childhood History (children only):

Weeks Premature		Complications with pregnancy		Birth weight	
Nursed		Formula changes		Newborn jaundice	
Diarrhea		Vomiting		Spitting	
Eczema		Immunizations up to date		Colic	
Normal Development		Daycare			

Please list all other illnesses (Past and Present): □ None	**Date:**

Please list all previous hospitalizations and operations: □ None	**Date:**

Female Reproductive: □ Surgically sterile □ Contraception □ Abstinence

Environmental Survey:

How long have you lived at your current residence: _____ Southern California

Prior Residences	**Dates**

Please check or complete:

□Water damage to carpeting □Indoor smoke □Allergy covers on bedding

□Comforter □Feather pillow □Stuffed animals in bedroom

□Air purifier □Indoor pets (list, how old?)_____

Family History *(please check):*

RELATION	**AGES**	**NASAL ALLERGY**	**ASTHMA**	**OTHER ALLERGIC PROBLEM**

Social History:

Smoking/Vaping(circle): ____packs/day for____years. Date quit:_____ □ Not applicable

Alcohol: # of drinks per day____week_____month_____ □ 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 loss____lbs.
- □ Weight gain____lbs.
- □ 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

GI/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
- □ Heart murmur

Blood/Lymph
- □ Swollen lymph nodes
- □ Blood clots
- □ Bleeding tendency
- □ Bruising

Scalp/Head
- □ Hair loss
- □ Scalp tenderness
- □ Jaw pain while chewing