

Allergy Questionnaire - Intake Questions

To Be Filled Out by Patient

Patient Name _____

Birthdate _____

Reviewed by _____

Date _____

1. Do you experience any of these symptoms more than twice per year: Cough, cold, congestion, difficulty breathing, headaches, wheezing, runny nose, sore throat, itchy/irritated eyes, sinus pain, ear pain, unexplained fatigue, skin irritation, snoring? Yes No
2. Have you ever been diagnosed with asthma or bronchitis? Yes No
3. Do you experience symptoms of allergies? Yes No
4. Regarding possible food allergies, do you experience any of the following: (check all that apply)
 - Bloating after eating
 - Constipation
 - Stomach pain
 - Nausea
 - Tingling of the mouth or any other unusual sensation
 - Diarrhea
 - Upset stomach
 - Indigestion
 - Vomiting

Allergy Questionnaire - Part 2

To be filled out with allergy counselor after initial screening

1. What symptoms are you experiencing? (From #1 on intake form) _____
2. How often do you experience these symptoms? _____
3. Do you have any of these symptoms?

<input type="checkbox"/> Cough	<input type="checkbox"/> Runny Nose	<input type="checkbox"/> Nasal Polyps	<input type="checkbox"/> Eczema
<input type="checkbox"/> Wheezing	<input type="checkbox"/> Nasal Congestion	<input type="checkbox"/> Poor Sense of Smell	<input type="checkbox"/> Hives / Swelling
<input type="checkbox"/> Shortness of breath	<input type="checkbox"/> Itchy Nose	<input type="checkbox"/> Ear Infections	<input type="checkbox"/> Headaches
<input type="checkbox"/> Chest tightness	<input type="checkbox"/> Itchy / Watery Eyes	<input type="checkbox"/> Sinus Infections	<input type="checkbox"/> Snoring
<input type="checkbox"/> Sneezing	<input type="checkbox"/> Postnasal Drip	<input type="checkbox"/> Blocked Ears	<input type="checkbox"/> Fatigue
<input type="checkbox"/> Phlegm/sputum (Color _____)		<input type="checkbox"/> Other _____	
4. Which of the following seems to bother you or trigger/cause the above symptoms?

<input type="checkbox"/> Grass	<input type="checkbox"/> Cats	<input type="checkbox"/> Cosmetics	<input type="checkbox"/> Drafts
<input type="checkbox"/> Nervousness	<input type="checkbox"/> Hay	<input type="checkbox"/> Dogs	<input type="checkbox"/> Aerosol sprays
<input type="checkbox"/> House Dust	<input type="checkbox"/> Cold Air	<input type="checkbox"/> Mold & Mildew	<input type="checkbox"/> Horses
<input type="checkbox"/> Perfumes	<input type="checkbox"/> Smoke	<input type="checkbox"/> Humidity	<input type="checkbox"/> Basements
<input type="checkbox"/> Other Animals	<input type="checkbox"/> Insecticides	<input type="checkbox"/> Pollution	<input type="checkbox"/> Weather changes
<input type="checkbox"/> Leaves	<input type="checkbox"/> Alcoholic beverages	<input type="checkbox"/> Odors	<input type="checkbox"/> Exercise
<input type="checkbox"/> Latex (rubber)	<input type="checkbox"/> Insect bites/stings. Describe reaction: _____		
<input type="checkbox"/> Foods. List foods and reactions: _____			
<input type="checkbox"/> Other. List sources and reaction: _____			
5. When are your symptoms worst? Year round

<input type="checkbox"/> January	<input type="checkbox"/> February	<input type="checkbox"/> March	<input type="checkbox"/> April
<input type="checkbox"/> May	<input type="checkbox"/> June	<input type="checkbox"/> July	<input type="checkbox"/> August
<input type="checkbox"/> September	<input type="checkbox"/> October	<input type="checkbox"/> November	<input type="checkbox"/> December
6. Are symptoms better away from home? Yes No If yes, when? _____
7. Have you ever had an allergy skin test or blood test? Yes No If yes, results: _____
8. Have you ever had allergy injections? Yes No If yes, when? _____
9. Have you received cortisone (prednisone, methylprednisolone, etc.) drugs? Yes No
If yes, when? _____ How much? _____
10. Are you on allergy medications? Yes No What meds? _____
How much? _____ For how long? _____
11. What is your occupation? (current or former) _____

THIS SECTION FOR PROVIDER AND OFFICE USE ONLY

Is patient...

- Suffering from uncontrolled asthma History of anaphylaxis

If yes to above, refer out to specialist

- On beta blocker? Pregnant? Heavily tattooed?

Significantly immunocompromised or have malignancy or severe chronic illness?

If yes to above, select blood test

Wheezing or having difficulty breathing?

Experiencing active hives or extensive dermatitis?

If yes to above, treat symptoms and schedule for another day

Having symptoms consistent with food allergies?

If yes to above, consider skin panel and food panel

Indications

Inhalant Panels: Skin Test Blood Test

Food Panels: Skin Test Blood Test

Schedule skin test for (Date): _____

Patient Name

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Allergy Questionnaire - Part 3

To be filled out by patient during test development

ENVIRONMENTAL SURVEY

1. How long have you lived in your house/apartment? _____
2. Do you live in a House Apartment/duplex Condominium/townhouse
3. Approximately how old is your home? _____
4. Do you live in City Suburbs Rural area
5. Do you have a basement? Yes No
6. Type of heating: hot air steam (radiator) electric hot water (baseboard)
7. Do you have: Wood /coal stove or fireplace Humidifier Dehumidifier Air cleaner
8. Number of pets (indoor or outdoor) ___Cats ___Dogs ___Birds ___Other
9. Are there any tobacco smokers in your home? Yes No
10. Is your bedroom in the basement? Yes No
11. Do you have allergy-proof encasing for pillow or mattress? Yes No
12. What type of pillows do you have? _____
13. What type of comforter do you have? _____
14. What type of floor covering do you have in your bedroom? Wall to wall Area rug Animal skin Bare floor
15. How old is your mattress? _____ What's inside your mattress? (i.e. cotton/horse hair) _____
16. Do you have air conditioning? Yes No If yes, is it: Window unit Central
17. Do you have problems with roaches or mice? Yes No
18. Do you have water leaks, mold contamination? Yes No
19. Is your home/apartment excessively humid? Yes No
20. Do you experience runny nose or sneezing in response to eating? Yes No
21. Do you experience runny nose or sneezing in response to strong odors? Yes No
22. Do you experience runny nose or sneezing in response to exercise? Yes No
23. Do you experience runny nose in response to emotional upset? Yes No

MEDICAL HISTORY

1. Check all that apply:

<input type="checkbox"/> Diabetes	<input type="checkbox"/> Liver disease/hepatitis	<input type="checkbox"/> Peptic ulcer	<input type="checkbox"/> Heartburn/reflux
<input type="checkbox"/> Cancer	<input type="checkbox"/> Heart problems/murmur	<input type="checkbox"/> Thyroid disease	<input type="checkbox"/> Seizures
<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Migraines
<input type="checkbox"/> Anemia/blood disorder	<input type="checkbox"/> Asthma	<input type="checkbox"/> Hay fever	<input type="checkbox"/> Depression
<input type="checkbox"/> Kidney/bladder disease	<input type="checkbox"/> Gynecological problems	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Anxiety
<input type="checkbox"/> Back problems	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Cataracts	<input type="checkbox"/> Loss of hearing
<input type="checkbox"/> Emphysema			
2. If yes to any of above, please explain: _____
3. Have you had your tonsils or adenoids removed? Yes No
4. Have you had ear, nose or sinus surgery? Yes No
5. If yes, please explain: _____
6. Who in your family has had: (NOT including yourself)

<input type="checkbox"/> Asthma _____	<input type="checkbox"/> Eczema _____
<input type="checkbox"/> Seasonal /year round allergies _____	<input type="checkbox"/> Sinus problems _____
<input type="checkbox"/> Other allergies (drugs/bee sting/food etc) _____	
7. Do you smoke? Yes No If yes, how much? _____
8. Have you smoked in the past? Yes No How long ago did you stop? _____
9. How many years did you smoke? _____

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