



Allergy Questionnaire



211850QALL

NAME: _____

DOB: _____

MR#: _____ HCL# : _____

LABEL or ADDRESSOGRAPH _____

Date _____

Referring or Personal Physician Name _____

Referring or Personal Physician Address _____

Would you like a report sent to him/her? Yes No

INSTRUCTIONS: CHECK, CIRCLE or DESCRIBE as indicated. If a particular question does not apply, leave blank and proceed.
 Person answering questions: _____

A. NASAL / EYE SYMPTOMS: Absent Present ▶ How long? _____

1. Is the problem:
 - a) Hay fever (sneeze, itchy eyes, runny nose) ?... Yes No
 - b) Nasal Congestion; stuffiness?..... Yes No
 - c) Sinusitis? Yes No
 - d) Frequent "colds"?..... Yes No
 - e) Nasal polyps? Yes No
2. Are these symptoms:
 - a) Present all year?..... Yes No
 - b) Worse during certain months?..... Yes No
 - Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
 - c) Worse with exposure to:
 - Smoke House dust Animals Odors Cold air Drafts Temperature changes Dampness
 - Raking leaves Lawn mowing Barns Preparing foods Eating foods Emotional upset
3. List other exposures which increase symptoms: _____
4. Are nose drops, sprays, or blood pressure pills used? Yes No

B. CHEST SYMPTOMS: Absent Present ▶ How long? _____

1. Is the problem:
 - a) Cough?..... Yes No
 - b) Wheezing?..... Yes No
 - c) Asthma?..... Yes No
 - d) Shortness of Breath?..... Yes No
 - e) Chest Tightness or Pain?.. Yes No
2. Are these symptoms:
 - a) Present all year?..... Yes No
 - b) Worse during certain months?..... Yes No
 - Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
 - c) Present only with "colds"?..... Yes No
 - d) Associated with bronchitis or pneumonia?..... Yes No
 - e) Made worse following use of aspirin?..... Yes No
 - f) Made worse with exercise?..... Yes No
 - g) Worse premenstrually? (women)..... Yes No
 - h) Worse with specific exposures as in question A-2-c above?..... Yes No

Please list: _____

C. OTHER ALLERGIC SYMPTOMS: Absent Present ▶ How long? _____

1. Hives or skin swelling? Yes No

Are they associated with:

 - a) Foods eaten? Yes No

Which ones? 1) _____ 2) _____ 3) _____ 4) _____
 - b) Medications taken? Yes No

Which ones? 1) _____ 2) _____ 3) _____ 4) _____
 - c) Other factors? _____
2. Eczema? Yes No
3. Skin rashes? Yes No
4. Any other symptoms? Yes No

Describe: _____

D. HAVE STINGS BY BEE, WASP, HORNET, OR YELLOW JACKET CAUSED UNUSUAL REACTIONS?: Yes No

Describe: _____

E. TREATMENT:

- List and bring all medications that are being used at the present time. Indicate how often you take them.

- What medications have helped? _____

- Has cortisone been used? No Yes
 When? _____
 Why? _____

- List any drug allergy. Include antibiotics, anesthetic agents, x-ray dye, vaccines, other: _____

 Describe reaction: _____

NAME:

DOB:

MR#:

HCL# :

LABEL or ADDRESSOGRAPH

F. PREVIOUS ALLERGIC INVESTIGATION AND TREATMENT:

- By whom? _____ City _____ State & Zip _____ When? _____
 Results of tests: _____
 Were allergy injections taken? No Yes ► When and how long? _____
 Reason treatment stopped: _____

G. FAMILY ALLERGY HISTORY (Please check in the appropriate space)

Relation	Age if Living	Age at Death	Eczema or Hives	Hay Fever	Asthma	Drug or Food Related	Other (Describe)
Father							
Mother							
Brothers							
Sisters							
Children							

H. ENVIRONMENT (Check or write answer)

- Current home: House Apartment Mobile Home ► In: City Suburb Farm
- Age of dwelling? _____ years How long occupied? _____ years
- Heating system: Forced air Gravity air Hot water or steam Space heater Wood ► Where stored? _____
- Is the home equipped with: Air cleaner No Yes Humidifier No Yes
 Air conditioner No Yes ► Central Window unit
- What industry or factory is nearby? _____
- Bedroom: Type of floor covering: _____ Type of pillow: _____ Age: _____
 Mattress: _____ Age: _____ Number of beds in room: _____
- Basement: No Yes ► Finished Unfinished Musty Damp Dry
- Are there animals or birds in the house? No Yes ► Specify type(s): _____
 How long? _____ Where sleeps? _____ Any previous pets? _____
- Is there anywhere in the house where the symptoms are worse? No Yes ► Where? _____
- What is your occupation? _____
- Are symptoms affected at: Job? No Yes ► How? _____
 School? No Yes ► How? _____
- Number of days absent from work or school per year because of symptoms: _____
- In what state did symptoms begin? _____ List other states in which you have lived and when: _____
- Does travel or vacations affect symptoms? No Yes ► How and where? _____
- Describe briefly hobbies and leisure time activities: _____
- Smoking history. Have you used tobacco regularly? No Yes
If Yes: **Age Started** **Duration in Years** **Average Amt/Day** **Do you still use?**
 Cigarettes _____ _____ _____ No Yes
 Cigars _____ _____ _____ No Yes
 Pipe _____ _____ _____ No Yes