

# ALLERGY QUESTIONNAIRE

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Address: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
City, State, Zip: \_\_\_\_\_ Home#: \_\_\_\_\_  
Gender(circle one): MALE FEMALE Work#: \_\_\_\_\_  
Primary Care Physician: \_\_\_\_\_ Referring Physician: \_\_\_\_\_

*Please answer the questions on this form as they relate to the person being evaluated.*

**Although your history and symptoms are very important in our analysis of your condition, it is also important for us that you understand:**

- *We do not treat symptoms or diseases.*
- *Allergy is not a disease, rather a condition.*
- *A symptom is an attempt by your body to tell you something.*
- *We will attempt to find the underlying cause.*
- *We do not use drugs in this program.*
- *There is no single “healthy” diet that will work for everyone.*
- *Just because food is considered “healthy”, does not mean it is “healthy” for you.*
- *Your diet consists of everything you **eat, drink, rub on your skin, or inhale.***
- *Our procedures are safe and painless.*

Briefly describe the reason for your visit and what you hope to accomplish: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## MEDICAL HISTORY/SYMPTOMS REVIEW:

Do you have problems with a heart valve, heart murmur, or congenital heart disease?  Yes  No If yes, please explain: \_\_\_\_\_  
\_\_\_\_\_

Do you have an illness that affects your immune system? (Common Variable Immunodeficiency, HIV/AIDS, Other Immunodeficiency)  Yes  No If yes, please specify: \_\_\_\_\_

Do you have an autoimmune disease? (Lupus, Rheumatoid Arthritis, Sarcoid, Scleroderma, etc.)  Yes  No If yes, please specify: \_\_\_\_\_

Do you have cancer? (Lymphoma, Leukemia, Multiple Myeloma, other)  Yes  No If yes, please specify: \_\_\_\_\_

Have you ever had a bone marrow or solid organ transplant? (Lung, Kidney, Liver)  Yes  No If yes, please specify: \_\_\_\_\_

Do you have problems with your spleen, lack of spleen or sickle cell anemia?  Yes  No If yes, please specify: \_\_\_\_\_

Do you have chronic back pain, problems with your discs, sciatica or carpal tunnel?  Yes  No If yes, please specify: \_\_\_\_\_

***Do you have recurrent or chronic problems with any of the following?***

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Frequent Headache            | <input type="checkbox"/> Chest Pain              | <input type="checkbox"/> Heartburn/Reflux           |
| <input type="checkbox"/> Vision Disturbance/Cataracts | <input type="checkbox"/> Pneumonia               | <input type="checkbox"/> Constipation               |
| <input type="checkbox"/> Wear Glasses                 | <input type="checkbox"/> High Blood Pressure     | <input type="checkbox"/> Diarrhea                   |
| <input type="checkbox"/> Wear Contact/Soft/Gas Perm   | <input type="checkbox"/> Rapid Heart Beat        | <input type="checkbox"/> Frequent/Painful Urination |
| <input type="checkbox"/> Frequent Cold, ____/Year     | <input type="checkbox"/> Nausea/Vomiting         | <input type="checkbox"/> Arthritis                  |
| <input type="checkbox"/> Diabetes                     | <input type="checkbox"/> Kidney/Bladder Disease  | <input type="checkbox"/> Cancer                     |
| <input type="checkbox"/> Anemia/Blood Disorder        | <input type="checkbox"/> Liver Disease/Hepatitis | <input type="checkbox"/> Heart Problems/Murmur      |
| <input type="checkbox"/> Gynecologic Problems         | <input type="checkbox"/> Glaucoma                | <input type="checkbox"/> Hay Fever                  |
| <input type="checkbox"/> Asthma                       | <input type="checkbox"/> Osteoporosis            | <input type="checkbox"/> Seizures                   |
| <input type="checkbox"/> Migraines                    | <input type="checkbox"/> Anxiety                 | <input type="checkbox"/> Thyroid Disease            |
| <input type="checkbox"/> Peptic Ulcer                 | <input type="checkbox"/> Loss of Hearing         | <input type="checkbox"/> Emphysema                  |
| <input type="checkbox"/> Depression                   | <input type="checkbox"/> Nausea/Vomiting         | <input type="checkbox"/> Arthritis                  |

If yes to any above, please explain: \_\_\_\_\_

\_\_\_\_\_

Briefly explain any other chronic symptoms: \_\_\_\_\_

\_\_\_\_\_

**AGE WHEN SYMPTOMS WERE FIRST OBSERVED**

- Infant (Age 0 -2)
- Child (Age 3 – 5)
- Child (Age 6 – 12)
- Adolescent (Age 13 – 18)
- Adult (Age 19 – 25)
- Adult (Age 26 – 40)
- Adult (Age 40)

**PREVIOUS DIAGNOSIS OF ALLERGY**

- Yes, and allergy shots helped.
- Yes, but allergy shots did not help
- Yes, and medication helped
- Yes, but medication did not help
- None

**FAMILY MEMBERS WITH ALLERGIC SYMPTOMS**

- Mother
- Father
- Brother/Sister
- Grandparents
- Son/Daughter
- Spouse
- None

**SKIN SYMPTOMS**

- Hives
- Rashes
- Itching
- Eczema
- Swelling
- Sores
- Once had rashes in the bends of knees and elbows
- Above symptoms are worse during known pollen seasons
- Above symptoms are worse with animal exposure
- Skin problems are rare
- Skin problems are chronic
- None

**EYE SYMPTOMS**

- Itching
- Excessive Watering
- Redness
- Swelling
- Above symptoms are worse during known pollen seasons
- Above symptoms are worse with animal exposure
- Tobacco smoke or chemical exposure makes symptoms worse
- Tobacco smoke or chemical exposure is the major cause of symptoms
- None

**NASAL SYMPTOMS**

- Itching
- Sneezing
- Runny Nose – Clear Discharge
- Frequent Nose Blowing
- Above symptoms are worse during known pollen seasons
- Above symptoms are worse with animal exposure
- Runny Nose – Cloudy Discharge
- Stuffiness
- Post Nasal Drip
- Frequent Sinus Infections
- Nasal Obstruction
- Loss of Smell
- None

**EAR SYMPTOMS**

- Itching
- Blocking, Fullness and Popping
- Hearing Loss
- Pain
- Frequent Ear Infections
- Ear Tubes Inserted
- Ringing in Ears
- None

**THROAT & MOUTH SYMPTOMS**

- Itching of the throat or mouth
- Frequent Sore Throats
- Frequent Laryngitis
- Frequent Tonsillitis
- Mouth Sores
- Swelling of the Tongue or Mouth
- None

**CHEST SYMPTOMS**

- Tightness
- Asthma or Wheezing with exercise
- Asthma or Wheezing when around animals
- Asthma or Wheezing during pollen seasons
- Asthma or Wheezing when around tobacco smoke or chemicals
- Shortness of Breath
- Dry Coughing
- Wet Coughing
- Emphysema
- Frequent Bronchitis
- Recurring Pneumonia
- Chest Pain
- None

**CHRONIC GASTROINTESTINAL SYMPTOMS**

- Nausea and Vomiting
- Diarrhea
- Gas, Heartburn
- Cramps or Bloating
- Abdominal Pain
- Re-taste Foods
- None

**BONE & JOINT SYMPTOMS**

- Joint or Bone Pain
- Muscle Pain
- Redness or Swelling of Joints
- Joint Stiffness, Limited Motion
- None

**FREQUENCY & SEVERITY OF ALLERGY SYMPTOMS**

- Constant, Chronic with Little Change
- Present Most of the Time
- Present Part of the Time
- Present Rarely
- No Interference with Normal Life
- Slight Interference with Normal Life
- Considerable Interference with Normal Life
- Prevents Some Normal Activities

**SYMPTOMS ARE WORSE**

- Outdoors, and better indoors
- At nighttime
- In the bedroom or when in bed
- During windy weather
- During wet or damp weather
- When the weather changes
- During known pollen seasons
- In certain rooms or buildings
- When exposed to tobacco smoke
- With yard work, cut grass, leaves, hay or barns
- When sweeping or dusting the house
- In areas with mold or mildew
- In air conditioning
- In fields or in the country
- Tobacco smoke bothers me more than anything else
- Don't know

**SYMPTOMS ARE BETTER**

- After shower or bath
- In air conditioning
- Indoors
- During or after physical activity
- After taking antihistamines
- With allergy shots
- Don't know

**ANIMALS, INSECTS AND BIRDS THAT CAUSE SYMPTOMS ON EXPOSURE**

- Dogs
- Cats
- Horses or Cattle
- Rodents (mice, guinea pigs, etc.)
- Rabbits
- Birds or Feathers
- Bees
- Other \_\_\_\_\_
- None

**FOOD RELATED SYMPTOMS**

- Symptoms flare 5 – 60 minutes after meals
- Some foods are craved or addictive
- The smell or odor of some foods increases symptoms
- Preservatives, additives or food coloring increase symptoms
- Some foods cause nasal symptoms
- Some foods cause asthma
- Some foods cause rashes or hives
- Some foods cause headaches
- Some foods cause swelling of mouth or tongue
- Some foods cause upset stomach or vomiting
- Some foods cause diarrhea
- Symptoms occur with restaurant salad bars or Asian foods
- Symptoms occur with any regularly eaten food
- None

**FOODS THAT CAUSE SYMPTOMS WITHIN 1 – 2 HOURS**

- Eggs
- Milk
- Beef
- Corn
- Wheat
- Soybean
- Peanut
- Pork
- Fish
- Shellfish
- Orange or other citrus
- Potato
- Tomato
- Yeast
- Chocolate
- Coffee or Tea
- Other: \_\_\_\_\_

**FOODS THAT CAUSE SYMPTOMS WITHIN 2 – 24 HOURS**

- Eggs
- Milk
- Beef
- Corn
- Wheat
- Soybean
- Peanut
- Pork
- Fish
- Shellfish
- Orange or other citrus
- Potato
- Tomato
- Yeast
- Chocolate
- Coffee or Tea
- Other: \_\_\_\_\_

**CHEMICALS THAT CAUSE SYMPTOMS**

- Insecticides & Pesticides
- Paints & Household Cleaners
- Perfumes & Cosmetics
- Gasoline or Automobiles Exhaust
- Stove or Furnace Emissions
- The Smell of New Fabrics or Fabric Store
- Chemicals in the workplace
- Laundry Detergent
- Newsprint
- Other: \_\_\_\_\_
- None

- When are your symptoms worse:
- |                                  |                                   |                                    |
|----------------------------------|-----------------------------------|------------------------------------|
| <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  |

Have you had your tonsils or adenoids removed?  Yes  No  
 Have you had ear, nose or sinus surgery?  Yes  No If yes, please explain: \_\_\_\_\_

What is your current weight? \_\_\_\_\_ What was your weight 1 year ago? \_\_\_\_\_

When was your last chest x-ray? \_\_\_\_\_ Results? \_\_\_\_\_

Have you ever had sinus x-rays? (Check one)  Yes  No If yes, please explain: \_\_\_\_\_

**MEDICATIONS:**

Do you take any of the following medications on a regular basis?

- Antihistamines  
(Benadryl, Actifed, Chlortrimeton, Tylenol Sinus, Tylenol Sleep, Dimetapp, Drixoral, Trimalin, Atarax, Claritin, Allegra, Zyrtec, etc.)
- Bronchodilators  
(Albuterol, Ventolin, Proventil, Serevent, or OTS's such as Primatine Mist, etc.)
- Steroid Inhalers  
(Asmacort, Flovent, Pulmicort, Beclovent, Aerobid, Advair, etc.)
- Nasal Steroids  
(Beconase, Flonase, Nasacort, Rhinocort, etc.)
- Medications that affect the immune system  
(Prednisone, Imuran, Methotrexate, Cellcept, Cytoxan, Cyclosporine, Tacrolimus, etc.)
- Chemotherapy

Please list any medications that you are currently taking: \_\_\_\_\_

**SOCIAL:**

Where were you born? \_\_\_\_\_ Where were you raised? \_\_\_\_\_

Where have you lived? \_\_\_\_\_

Check applicable box:  *Single*  *Married*  *Divorced*  *Widowed*

How many children to you have? \_\_\_\_\_ What are their ages? \_\_\_\_\_

Do you exercise?  Yes  No If yes, how often? \_\_\_\_\_/week How long? \_\_\_\_\_ workout

Do you drink alcohol?  Yes  No If yes, how often? \_\_\_\_\_times/week How much? \_\_\_\_\_ drinks/day

**SMOKING:**

Do you presently smoke?  Yes  No If yes, average number of cigarettes per day: \_\_\_\_\_

If yes, at what age did you start? \_\_\_\_\_

Have you ever smoked?  Yes  No If yes, how many years? \_\_\_\_ When did you quit? \_\_\_\_\_

Average number of cigarettes that you smoke per day: \_\_\_\_\_

Does anyone smoke in your home?  Yes  No

Have you ever had a reaction to x-ray dye?  Yes  No If yes, please explain: \_\_\_\_\_

**PREVIOUS ALLERGY EVALUTION:**

Have you ever seen an allergist?  Yes  No If yes, allergist's name: \_\_\_\_\_

Have you had allergy skin testing?  Yes  No If yes, Date: \_\_\_\_\_

Did you have any positive reactions?  Yes  No If yes, please list positive allergens (include any medications):

\_\_\_\_\_  
\_\_\_\_\_

Have you ever received allergy injections? Yes No

If yes, did your symptoms improve while receiving injections? Yes No If yes, please explain:

\_\_\_\_\_

Have you ever received Cortisone? (Prednisone, Methylprednisolone, etc.) drugs? Yes No If yes, how long ago? \_\_\_\_\_ How much? \_\_\_\_\_

**ENVIRONMENTAL SURVEY:**

Do your symptoms disturb your sleep? Yes No

Are your symptoms better when away from home? Yes No

Do you live in a: House Apartment/Duplex Condominium/Townhouse

How long have you lived in your house/apartment/condominium? \_\_\_\_\_

Do you live in: The City The Suburbs Rural Area

Do you have a basement? Yes No Is your house built on a slab? Yes No

Type of heating system: Hot Air Steam (radiator) Electric Hot Water (baseboard)

Do you have: Wood/Coal Stove Humidifier Dehumidifier Air Cleaner

**PETS:**

*(This section is only for those who own any pets)*

How many of the pets do you own?

Cats \_\_\_\_\_ Dogs \_\_\_\_\_ Birds \_\_\_\_\_ Other \_\_\_\_\_

Are they indoor or outdoor pets? \_\_\_\_\_

**SCHOOL HISTORY:**

Do you attend school? Yes No If yes, at what grade level? \_\_\_\_\_

Is your classroom: Carpeted Tile Other Are there any animals in your classroom? Yes No

Have you missed school due to allergies or asthma? Yes No If yes, how many days did you miss last year because of allergies or asthma? \_\_\_\_\_

**WORK ENVIRONMENT:**

What is your occupation? \_\_\_\_\_

Where are you employed? \_\_\_\_\_

How long have you worked there? \_\_\_\_\_

Is your workplace: Carpeted Tile Other

Is there air conditioning? Yes No Is smoking permitted? Yes No

Are you exposed to chemicals or strong odors? Yes No If yes, briefly explain: \_\_\_\_\_

\_\_\_\_\_

Are your symptoms worse while at work? Yes No If yes, briefly explain: \_\_\_\_\_

\_\_\_\_\_

Have you missed time from work due to allergies or asthma? Yes No If yes, how much time have you missed in the past year? \_\_\_\_\_



**IF THE PATIENT IS A CHILD, PLEASE COMPLETE THE FOLLOWING:**

Place of Birth: \_\_\_\_\_ Mother's Age at Birth: \_\_\_\_\_

Was Pregnancy/Labor/Delivery Normal?  Yes  No If no, please explain: \_\_\_\_\_

Birth Weight: \_\_\_\_\_ Formula or Breast Fed? \_\_\_\_\_ Well Tolerated? \_\_\_\_\_

Has child reached normal growth milestones?  Yes  No If no, please explain: \_\_\_\_\_

Your relationship to child: \_\_\_\_\_