ALLERGY QUESTIONNAIRE

ALLERGY & ASTHMA CONSULTANTS OF CENTRAL FLORIDA
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Patient's Name	**Date of Birth**
Date of Appointment	**Referring Physician**

1. INSTRUCTIONS:

Please answer the questions as they relate to the person being evaluated. A complete, accurate record is important in learning about your allergy problem. Bring this completed form for your first appointment.

Briefly describe the reason for your allergy visit and what you hope to accomplish. _____

2. PROBLEMS

Have you ever had the following conditions?

Yes	No	(Check all items)	Age at onset	Severity			Comments
				Mild	Mod.	Sev.	
		Asthma (Wheezing)					
		Any Other Breathing Problems					
		Sinus Trouble					
		Hay Fever (Runny, stuffy, itchy nose; sneezing)					
		Hives or Swelling					
		Eczema or Other Rashes					
		Frequent Infections					
		Food Reactions					
		Drug Reactions					
		Insect Reactions					

3. SYMPTOMS

Have you ever had the following? If not, leave blank.

	How many days in the last month	Severity			Circle the Months Most Severe
		Mild	Mod	Sev	
Runny or stuffy nose					**J F M A M J J A S O N D**
Itchy nose					**J F M A M J J A S O N D**
Sneezing					**J F M A M J J A S O N D**
Itchy eyes					**J F M A M J J A S O N D**
Wheezing					**J F M A M J J A S O N D**
Coughing					**J F M A M J J A S O N D**
Wheezing or coughing with exercise					**J F M A M J J A S O N D**
Skin problems					**J F M A M J J A S O N D**

4. FOOD REACTIONS

Have you ever had any symptoms (rash, hay fever, vomiting, gas, cramps, diarrhea, colic as an infant) after the ingestion of any food or liquid? If yes, specify below.

Food	Approximate Date	Symptoms	Can food be eaten?		Date food was last eaten?
			Yes	No	

Reviewed By _____ Date _____

Patient's Name _____ Date _____

5. PRECIPITATING FACTORS / TRIGGERS:

For each item below, check the appropriate square to indicate whether your (or your child's) condition is affected by the following precipitants/triggers.

	Condition Made Worse	Condition Improved	No Change
Cutting or playing in grass, raking leaves	☐	☐	☐
Exposure to animals Specify: _____	☐	☐	☐
High winds, riding in auto	☐	☐	☐
Other outdoor exposure	☐	☐	☐
Moldy/mildewed areas or items (basement, attic, etc.)	☐	☐	☐
Sweeping, dusting or vacuuming	☐	☐	☐
Smog, smoking or smoke exposure	☐	☐	☐
Air conditioning or heating	☐	☐	☐
Cold Weather	☐	☐	☐
Paint lacquer, glue, mothballs, motor fumes, chemicals, fertilizers, insect spray, cooking odors, etc. Specify: _____	☐	☐	☐
"Colds" or viruses	☐	☐	☐
Trips away from home	☐	☐	☐
Other strong odors (perfume, etc.) Specify: _____	☐	☐	☐
Medications:			
• Antihistamines or cold preparations	☐	☐	☐
• Asthma medications	☐	☐	☐
• Nose Drops or spray. How often per day _____?	☐	☐	☐
• Aspirin	☐	☐	☐
• Other: _____			
Physical exertion or exercise	☐	☐	☐
Cleaning agents, detergents, ammonia, bleach, soap, conditioner, shaving cream, toothpaste, etc. Specify: _____	☐	☐	☐
Other factors _____			

6. RESIDENCE:

List your past residences with your most recent first. Only city and state required.

City & State	Effect on Symptoms (better, worse, no change)
1. _____	
2. _____	
3. _____	
4. _____	
5. _____	

7. PREVIOUS ALLERGY EVALUATION AND THERAPY

Have you ever had allergy skin tests?
☐ Yes ☐ No If yes, date _____ Physician's Name _____

Results of these tests: (If possible, please provide us with a copy)

_____

_____

_____

Have you ever received allergy injections?
☐ Yes ☐ No If yes, give dates _____

Please list all medications that you are now taking – name, dosage, number of times a day.
Bring all these with you for your first appointment. _____

_____

_____

Please list all medications you have taken for allergies in the past _____

_____

_____

_____

Reviewed By _____ Date _____

Patient's Name _____ Date _____

8. OTHER MEDICAL PROBLEMS:

Have you ever had any of the following? Answer all items.

Check all items	Yes	No		Yes	No		Yes	No
Ear Infections – number past year_____	☐	☐	Pneumonia, number past year _____	☐	☐	Liver Trouble (e.g. Hepatitis)	☐	☐
Frequent Nosebleeds	☐	☐	Coughed Up Blood	☐	☐	Kidney or Bladder Trouble	☐	☐
Nasal Polyps	☐	☐	Tuberculosis	☐	☐	Frequent Diarrhea	☐	☐
Operation on Sinuses	☐	☐	Chest X-Ray	☐	☐	Sexual Problems	☐	☐
Sinus X-Rays	☐	☐	Heart Trouble	☐	☐	Bedwetting	☐	☐
Frequent Headaches	☐	☐	High Blood Pressure	☐	☐	Poison Ivy or Poison Oak	☐	☐
Hearing Problems	☐	☐	Diabetes	☐	☐	Other:	☐	☐
Glaucoma	☐	☐	Frequent Heartburn	☐	☐	_____		
Tonsils / Adenoids Removed (date)_____	☐	☐	Colic or Spitting up as an Infant	☐	☐	_____		

9. IMMUNIZATIONS:

(List dates and reactions, if any.)

Polio _____ Measles _____
DPT _____ Rubella (German Measles) _____
Tetanus Booster _____ Influenza _____
Other (Pneumovax) _____
_____

10. HOSPITALIZATIONS:

List most recent first	Reason	Date
1.		
2.		
3.		
4.		
5.		

11. SURGERY

List most recent first	Reason	Date
1.		
2.		
3.		
4.		
5.		

12. FAMILY HISTORY

Do any members of your family have a history of allergy?

	Yes	No	If yes, list all relatives (e.g. parents, brothers & sisters, children, aunts, uncles, grandparents, etc.)
Asthma			
Hay Fever			
Eczema			
Hives			
Swelling			
Frequent Pneumonia			
Headaches			
Other Allergies			

Reviewed By _____ Date _____

Patient's Name _____ Date _____

Is there a family history of any other illnesses?	Yes	No	If yes, list all relatives
Emphysema or Other Lung Disease			
Cystic Fibrosis			
Tuberculosis			
Thyroid Disease			
Glaucoma			
Diabetes			
Other			

13. ENVIRONMENTAL SURVEY

Where do you live? (city or rural)	Number of Indoor Plants
Age of House: years	House construction (brick, wood, etc.)
Are any rooms damp or musty?	Do you have: (a) an air cleaner? (b) an air dehumidifier?
Type of heating (forced air, steam, space heater, baseboard, electric)	Type of air conditioning (central, window, etc.)

Type of Carpet (wool, synthetic, jute) / Type of Pad (rubber, ozite, hair)	Bedrooms	Living Room	Den	Dining Room
	Carpet			
	Pad			

How old is your: Pillow? Mattress?

Do you have any: Stuffed Furniture? Feather Comforters?

Is your pillow: ☐ feather ☐ foam rubber ☐ dacron ☐ other ☐ encased in plastic

Is your mattress: ☐ foam rubber ☐ cotton ☐ innerspring & cotton ☐ waterbed ☐ encased in plastic ☐ other

What kind of grasses, shrubs and trees are in the immediate vicinity of your house?

Do you have pets? List number and kind (dog, cat, birds, horses, etc.)

Do your pets spend time indoors? ☐ Yes ☐ No

What type of work do you do?

Are you exposed to anything at work that might aggravate your condition? Which things?

Have you missed any time from work or school because of your allergies? How much time?

Do you have any other exposures from hobbies, recreational activities, etc.?

14. EDUCATION

Grade School (Highest grade)_____ High School (1 2 3 4)

College (1 2 3 4) Other_____

15. MARITAL STATUS

☐ Married ☐ Single

☐ Widowed ☐ Separated Number of Children_____

16. EVALUATION

How would you describe yourself (or child if he/she is being evaluated)? Check those that apply.

☐ Timid ☐ Concerned
☐ Quiet ☐ Depressed
☐ Aggressive ☐ Bustling
☐ Forward ☐ Happy
☐ Unfriendly ☐ Anxious
☐ Introvert ☐ Many Friends
☐ Tense ☐ Shy
☐ Calm ☐ Relaxed
☐ Well Adjusted ☐ Independent
☐ Few friends ☐ Manipulative
☐ Spoiled ☐ Extrovert
☐ Dependent ☐ Usually Ill

17. SMOKING / WEIGHT

Have you ever smoked? ☐ Yes ☐ No

If Yes, how many years? _____

Do you presently smoke? ☐ Yes ☐ No

When did you stop? _____

Average cigarettes per day at highest point? _____

If you still smoke, do you think you could stop? ☐ Yes ☐ No

Which other family members now smoke in your home?

_____

_____

_____

Weight now _____ Weight one year ago_____

Maximum weight _____ When?_____

BRING THIS COMPLETED FORM WITH YOU FOR YOUR FIRST APPOINTMENT

Reviewed By _____ Date _____