PLEASE ANSWER THE FOLLOWING QUESTIONS AS ACCURATELY AS POSSIBLE

1. What are the main symptoms that you are having? _____

   _____

   _____

2. For how long have you had these symptoms? _____

3. Please indicate which of the following symptoms you have: (Circle)

HEAD / NOSE / THROAT

- ☐ SNEEZING
- ☐ RUNNY NOSE
- ☐ CLEAR DRAINAGE
- ☐ COLORED DRAINAGE
- ☐ ITCHING OF NOSE
- ☐ NASAL CONGESTION
- ☐ SINUS INFECTIONS
- ☐ SNORING
- ☐ HEADACHE
- ☐ DRAINAGE IN BACK OF THROAT
- ☐ FREQUENT CLEARING OF THROAT
- ☐ FREQUENT SORE THROAT
- ☐ ITCHING OF THROAT / MOUTH
- ☐ EARS BLOCKED
- ☐ RED EYES
- ☐ WATERY EYES
- ☐ ITCHING OF EYES
- ☐ PUFFY EYES

CHEST

- ☐ WHEEZING
- ☐ DRY COUGH
- ☐ PRODUCTIVE COUGH
- ☐ CHEST TIGHTNESS
- ☐ SHORTNESS OF BEATH
- ☐ ASTHMA ATTACKS
- ☐ LUNG INFECTIONS
- ☐ PNEUMONIA

SKIN

- ☐ HIVES
- ☐ ECZEMA
- ☐ ITCHING
- ☐ OTHER RASH

INSECT STINGS

- ☐ HIVES
- ☐ THROAT SWELLING
- ☐ HOARSENESS
- ☐ SHORTNESS OF BREATH
- ☐ ITCHING AT STING SITE
- ☐ ITCHING AWAY FROM STING SITE
- ☐ WHEEZING
- ☐ DIZZINESS
- ☐ LOSS OF CONSCIOUSNESS

OTHER SYMPTOMS: Describe

_____

_____

_____

_____

_____

Date of last Pneumovax Vaccine _____ Location _____

Date of last Prevnar 13 _____ Location _____

Date of last Flu Vaccine _____ Location _____

FOR OFFICE USE ONLY

Date: _____ Patient Name: _____

QUESTIONNAIRE REVIEWED WITH PT BY MD _____

4. How long have you had these symptoms?

Head / Nose / Throat Symptoms (years) _____ Insect Sting Reactions (dates) _____
Chest Symptoms (years) _____ Other Symptoms (years) _____
Skin Symptoms (years) _____

5. What is the pattern of your symptoms?

	HEAD / NOSE / THROAT	CHEST	SKIN
Year Round, No Seasonal Variation			
Year Round, Worse Seasonally			
Only Seasonal			

If Seasonal, List Months _____

6. Which of the following increase your symptoms? (Please Check)

House Dust	☐	Perfumes	☐	Weather Changes	☐	Drugs	☐
Cats	☐	Cosmetics	☐	Cold Weather	☐	Alcohol	☐
Dogs	☐	Soaps	☐	Hot Weather	☐	Medicines	☐
Other Animals	☐	Detergents	☐	Damp Weather	☐	Aspirin	☐
Hay	☐	Smoke	☐	Temperature Changes	☐	Foods	_____
Mowed Grass	☐	Paint	☐	Windy Days	☐		_____
Dead Grass	☐	Hairspray	☐	Mornings	☐		_____
Dead Leaves	☐	Outside Dust	☐	Afternoon	☐		_____
Feathers	☐	Strong Odors	☐	Evenings	☐	Other	_____
Latex Gloves	☐	Condoms	☐	Balloons	☐		_____

7. Do you have any of the following:

Stomach Ulcer (Peptic Ulcer)	Yes _____	No _____
Diabetes	Yes _____	No _____
High Blood Pressure	Yes _____	No _____
Glaucoma	Yes _____	No _____
Other Problems With Stomach or Bowels	Yes _____	No _____
Other Problems With Heart	Yes _____	No _____
Other Endocrine Problems (Thyroid, Etc.)	Yes _____	No _____
Problems with Nervous System	Yes _____	No _____
Problems with Kidneys / Urinary Tract	Yes _____	No _____
Problems with Blood	Yes _____	No _____
Problems with Bones Or Joints	Yes _____	No _____

8. Have you every had allergy tests before? Yes _____ No _____
If yes, Where? _____ Doctor _____ Year _____ Skin or Blood Test _____
Results _____

9. Have you ever been on allergy shots (immunotherapy, desensitization)? Yes _____ No _____
If yes, When? (approximate month & year) From _____ to _____
Did they help? Yes _____ No _____

10. Have you ever had a sinus x-ray or CT scan? Yes _____ No _____ If yes, when? _____
11. Have you every had a chest x-ray? Yes _____ No _____ If yes, when? _____

Date: _____ Patient Name: _____

12. List all hospitalizations in order of most recent:

	Reason for Hospitalization	Year When Hospitalized
1.		
2.		
3.		
4.		
5.		

13. List any medical problems that you have not already listed:

_____

_____

14. What medications do you use for relief of allergy symptoms?

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

15. List other drugs that you use regularly for any reason – both prescription and over the counter:

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

16. List any drugs that you use occasionally for any reason:

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

17. Do you use nose sprays? Yes _____ No _____ If yes, how often? Occasionally _____ Regularly _____
Name of nose spray: _____

18. Are you allergic to any medications? Yes _____ NO _____
If yes, please indicate:

	Name of Drug	Type of Reaction
1.		
2.		
3.		
4.		
5.		

Date: _____ Patient Name: _____

19. Is there a history of the following in your family?

	Yes	No	Relative (Mother, Father, Sibling, etc.)
Asthma	_____	_____	_____
Hay Fever	_____	_____	_____
Eczema	_____	_____	_____
Cystic Fibrosis	_____	_____	_____
Immune Deficiency	_____	_____	_____
Emphysema	_____	_____	_____
Lupus	_____	_____	_____
Rheumatoid Arthritis	_____	_____	_____

20. How old is your home? _____ How long have you lived there? _____
Is it wood / brick / trailer / apartment? _____ Number of stories _____
Any water or flood damage? Yes _____ No _____ If yes, where? _____
Is your home carpeted? Yes _____ No _____ If yes, where? _____
What kind of bed do you sleep on? (mattress, boxspring, waterbed) _____
What type of pillow do you sleep on? (feather, foam, synthetic) _____
How is your house cooled? _____ How is your house heated? _____

21. Do you smoke? Yes _____ No _____ Have you every smoked? Yes _____ No _____
How many packs per day do you smoke? _____ How long have you smoked? _____
If you quit, when? _____
Are there any smokers in your home? Yes _____ No _____ Who? _____

22. Please circle any of the following items that you have:

☐ Cats (Inside / Outside)	☐ Ceiling Fans	☐ Fireplace
☐ Dogs (Inside / Outside)	☐ Window Fans	☐ Wood Stove
☐ Indoor Birds	☐ Floor Fans	☐ Basement
☐ Cockroaches	☐ Stuffed Animals	☐ Mold / Mildew
☐ Other Animals	☐ Down Comforter	☐ House Plants
☐ Curtains / Blinds / Shutters / Shades		

23. Where do you work? _____
Are your symptoms worse at work? Yes _____ No _____

24. What hobbies do you have? _____

25. Please answer the following if the patient is a child under the age of 10 years:
Birth weight _____ C-Section or Vaginal Delivery? _____
Any Pregnancy or Delivery Complications? Yes _____ No _____
Bottle or Breast Fed? _____ Up-To-Date Immunizations? Yes _____ No _____
Attends Daycare or Similar? Yes _____ No _____

26. Additional Comments: _____

Date: _____ Patient Name _____