

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)

<u>HEAD / NOSE / THROAT</u>	<u>CHEST</u>	<u>SKIN</u>	<u>INSECT STINGS</u>
SNEEZING	WHEEZING	HIVES	HIVES
RUNNY NOSE	DRY COUGH	ECZEMA	THROAT SWELLING
CLEAR DRAINAGE	PRODUCTIVE COUGH	ITCHING	HOARSENESS
COLOR DRAINAGE	CHEST TIGHTNESS	OTHER RASH	SHORTNESS OF BREATH
ITCHING OF NOSE	SHORTNESS OF BEATH		ITCHING AT STING SITE
NASAL CONGESTION	ASTHMA ATTACKS		ITCHING AWAY FROM STING SITE
SINUS INFECTIONS	LUNG INFECTIONS		WHEEZING
SNORING	PNEUMONIA		DIZZINESS
HEADACHE			LOSS OF CONSCIOUSNESS
DRAINAGE IN BACK OF THROAT			
FREQUENT CLEARING OF THROAT			
FREQUENT SORE THROAT			

ITCHING OF THROAT / MOUTH

OTHER SYMPTOMS: Describe \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

EARS BLOCKED

RED EYES

WATERY EYES

ITCHING OF EYES

PUFFY EYES

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) \_\_\_\_\_  
Chest Symptoms (years) \_\_\_\_\_  
Skin Symptoms (years) \_\_\_\_\_

Insect Sting Reactions (dates) \_\_\_\_\_  
Other Symptoms (years) \_\_\_\_\_

5. What is the pattern of your symptoms?

	<u>HEAD / NOSE / THROAT</u>	<u>CHEST</u>	<u>SKIN</u>
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:

<u>Reason for Hospitalization</u>	<u>Year When Hospitalized</u>
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:

<u>Name of Drug</u>	<u>Type of Reaction</u>
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____

Date: \_\_\_\_\_ Patient Name: \_\_\_\_\_

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

	<u>Yes</u>	<u>No</u>	<u>Relative (Mother, Father, Sibling, etc.)</u>
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 \_\_\_\_\_