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 _____