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## ALLERGY QUESTIONNAIRE

**INSTRUCTION:** Please answer these questions as they relate to you or your child (the patient). Complete information is very helpful in learning about you or your child's allergy problem. Please bring this completed form to your first appointment.

**Patient's Name**

### 1. MAIN CONCERNS:

Briefly, describe the reason for your allergy visit and what you hope to accomplish:

### 2. PROBLEMS: Have you/your child ever had any of the following?

Yes	Please <b>CHECK ALL</b> items that apply	How severe?			How long (mo, yr)?	Comments
		Mild	Moderate	Severe		
<input type="checkbox"/>	Asthma (wheezing or coughing)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/>	Other breathing problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/>	Sinus trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/>	Hay fever (runny, stuffy, or itchy nose)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/>	Itchy, watery or red eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/>	Hives or swelling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/>	Eczema or other rashes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/>	Frequent infections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		

### 3. ALLERGIC REACTIONS: Have you/your child ever had any symptoms (rash, hay fever, vomiting, diarrhea, coughing or wheezing) after having the following items below? If yes, explain:

Yes	What type?	Dates and Symptoms
<input type="checkbox"/>	Food:	
<input type="checkbox"/>	Medicine:	
<input type="checkbox"/>	Vaccine:	
<input type="checkbox"/>	Insect bite:	
<input type="checkbox"/>	Latex or X-ray dye:	

#### 4. TRIGGERS:

For each item below, check the appropriate square to indicate whether you/your child is affected by the following:

	Symptoms worse	Symptoms Improved	No change		Symptoms worse	Symptoms improved	No change
Cutting or playing in grass	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Medicines:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other outdoor activities: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	•Antihistamines or cough/cold medicine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Moldy/mildewed areas (basement, attic, etc)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	•Asthma medicine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sweeping, dusting or vacuuming	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	•Nose drops or spray	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Smog or smoke exposure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Summer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Air conditioning or heating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Spring	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chemicals, strong odor, perfume, soap, detergents, or other: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Winter	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Trips away from home or while at school	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Exposure to animals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	"Colds" or viruses	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Other factors: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

#### 5. PREVIOUS ALLERGY EVALUATION & TREATMENT:

Have you/your child had previous allergy skin tests or blood test? Yes  No

If Yes, Where? \_\_\_\_\_ Doctor's name? \_\_\_\_\_

Results of these tests (if possible, provide us with a copy)

Have you/your child ever received allergy shots? Yes  No  If Yes, From \_\_\_\_\_ to \_\_\_\_\_ (mo/yr)

#### 6. MEDICATIONS:

Please list all medicines you are now taking.  
Please bring all of these with you for your appointment.

Name	Dosage	Name	Dosage
1. _____	_____	5. _____	_____
2. _____	_____	6. _____	_____
3. _____	_____	7. _____	_____
4. _____	_____	8. _____	_____

**7. OTHER MEDICAL PROBLEMS:**Have you ever had any of the following? (Check All Items that apply)

Yes

- Frequent headaches  
 Frequent nosebleeds  
 Nasal polyps  
 Operation on sinuses  
 Hearing problems  
 Glaucoma  
 Frequent ear infections  
 Pneumonia

Yes

- Diabetes  
 Coughed up blood  
 Sinus X-Rays, CT scans  
 Chest X-ray  
 Heart trouble  
 High blood pressure  
 Colic or spitting up (as infant)  
 Frequent heartburn

Yes

- Frequent diarrhea  
 Sexual problems  
 Liver trouble (e.g. hepatitis)  
 Kidney or bladder trouble  
 Poison ivy  
 Skin infections  
 Other? \_\_\_\_\_

**8. HOSPITALIZATIONS:**

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

1.  
2.  
3.

**9. SURGERY:**

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

1.  
2.  
3.

**10. FAMILY HISTORY:**

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

Yes

- Asthma  
 Hay fever  
 Eczema  
 Hives or swelling  
 Any immune diseases  
 Frequent pneumonia or lung diseases  
 Cancer  
 Cystic fibrosis  
 Tuberculosis  
 Thyroid disease  
 Glaucoma  
 Diabetes

If YES, list all relatives (parents, brothers, sisters, children, aunts, uncles, and grandparents).

### 11. ENVIRONMENTAL SURVEY:

Where do you live? City  County  Do you **own**  or **rent**  your home? How old is your home? \_\_\_\_\_  
House  Apartment  Are any rooms damp or musty? **Yes**  **No**

Please check the boxes if you have the following items in these rooms in the house:

	Bedrooms	Living Room	Dining Room	Other Rooms
<b>Carpet?</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Area rug?</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Ceiling fan?</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Central air condition?</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

How old is your pillow? \_\_\_\_\_ How old is your mattress? \_\_\_\_\_

Is your pillow:  Feather  Encased in plastic  Other \_\_\_\_\_  
Is your mattress:  Innerspring and cotton  Encased in plastic  Other \_\_\_\_\_

Do you have any: Stuffed furniture? **Yes**  **No**  Feather blankets? **Yes**  **No**

What kinds of grasses, shrubs and trees are near your house? \_\_\_\_\_

Do you have pets? **Yes**  **No**  List number and kind (dog, cat, birds, horses, etc.) \_\_\_\_\_

Do your pets spend time indoors? **Yes**  **No**

### 12. WORK ENVIRONMENT:

Do you work or go to school? **Yes**  **No**

What type of work do you do? \_\_\_\_\_

Are you exposed to anything at work or school that makes these symptoms worse? **Yes**  **No**   
What things? \_\_\_\_\_

Have you missed any time from work or school because of allergies? **Yes**  **No**  How many days in the last year? \_\_\_\_\_

Does your sports, hobbies, recreations or other activities make these symptoms worse? **Yes**  **No**

### 13. MARITAL STATUS:

Married  Single  Divorced  Widowed  Separated Number of children: \_\_\_\_\_

### 14. SMOKING HISTORY (PARENTS AND/OR PATIENT):

Have you ever smoked? **Yes**  **No**  How many years? \_\_\_\_\_

Do you smoke now? **Yes**  **No**  If No, when did you stop? \_\_\_\_\_ If Yes, how many cigarettes per day? \_\_\_\_\_

**BRING THIS COMPLETED FORM WITH YOU FOR YOUR FIRST APPOINTMENT. THANK YOU**