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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	**Date of Birth**

1. MAIN CONCERNS (Chief Complaint):

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 CHECK ALL items that apply	How severe?			How long (mo, yr)?	Comments
		Mild	Moderate	Severe		
☐	Asthma (wheezing or coughing)	☐	☐	☐		
☐	Other breathing problems	☐	☐	☐		
☐	Sinus trouble	☐	☐	☐		
☐	Hay fever (runny, stuffy, or itchy nose)	☐	☐	☐		
☐	Itchy, watery or red eyes	☐	☐	☐		
☐	Hives or swelling	☐	☐	☐		
☐	Eczema or other rashes	☐	☐	☐		
☐	Frequent infections	☐	☐	☐		

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
☐	Food:		
☐	Medicine:		
☐	Vaccine:		
☐	Insect bite:		
☐	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
Cutting or playing in grass	☐	☐	☐
Other outdoor activities:_____	☐	☐	☐
Moldy/mildewed areas (basement, attic, etc)	☐	☐	☐
Sweeping, dusting or vacuuming	☐	☐	☐
Smog or smoke exposure	☐	☐	☐
Air conditioning or heating	☐	☐	☐
Chemicals, strong odor, perfume, soap, detergents, or other:_____	☐	☐	☐
Trips away from home or while at school	☐	☐	☐
Exercise	☐	☐	☐

	Symptoms worse	Symptoms improved	No change
Medicines: •Antihistamines or cough/cold medicine	☐	☐	☐
•Asthma medicine	☐	☐	☐
•Nose drops or spray	☐	☐	☐
Summer	☐	☐	☐
Spring	☐	☐	☐
Winter	☐	☐	☐
Exposure to animals	☐	☐	☐
"Colds" or viruses	☐	☐	☐
Other factors:_____	☐	☐	☐

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 <u>all</u> medicines you are now taking.
Please <u>bring all of these with you</u> 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		Yes		Yes	
☐	Frequent headaches	☐	Diabetes	☐	Frequent diarrhea
☐	Frequent nosebleeds	☐	Coughed up blood	☐	Sexual problems
☐	Nasal polyps	☐	Sinus X-Rays, CT scans	☐	Liver trouble (e.g. hepatitis)
☐	Operation on sinuses	☐	Chest X-ray	☐	Kidney or bladder trouble
☐	Hearing problems	☐	Heart trouble	☐	Poison ivy
☐	Glaucoma	☐	High blood pressure	☐	Skin infections
☐	Frequent ear infections	☐	Colic or spitting up (as infant)		
☐	Pneumonia	☐	Frequent heartburn	☐	Other? _____

8. HOSPITALIZATIONS:

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

9. SURGERY:

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

10. FAMILY HISTORY:

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

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

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

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
Carpet?	☐	☐	☐	☐
Area rug?	☐	☐	☐	☐
Ceiling fan?	☐	☐	☐	☐
Central air condition?	☐	☐	☐	☐

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.)_____

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?_____

COMPLETED BY:_____ **REVIEWED BY:** _____

Patient or Parents **Nathan Tang, MD**

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