Allergy & Asthma Center of Fredericksburg, Ltd

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Allergy Questionnaire **Date: ________________________**

Please print out this questionnaire and complete it and remember to bring it with you for your first visit. The purpose of this questionnaire is to obtain the most complete and accurate history of your allergy problems. Many of the questions may not deal directly with your specific allergies, but please answer all the questions which pertain to you and your general health. Freely refer to any medical or environmental records you have including labels on pillows and mattresses, baby books, check books and other records you have at home. Please also have your other doctors send to you reports of any related x-rays or laboratory tests, although do not delay the appointment with us until all the records are in.

Please do not take any anti-histamines for 5-7 days before your visit for allergy testing. This includes such medications as Benadryl, Chlortimeton, Claritin, Clarinex, Zyrtec, Allergra, Atarax(Hydroxyzine) and some other prescription and over-the-counter cold and cough medications. Please ask us if any of your medications contain an anti-histamine. You do not need to stop your asthma medications, inhalers, nasal sprays, heart, blood pressure, thyroid or most other medications. Please call us if you feel you cannot stay off anti-histamines for 5-7 days so we can make other arrangements.

Name: ________________________________ Sex: M _____F_____

Address: ________________________________ Date of Birth:___________________

Contact Info: Home Phone: _________________________ Cell Phone:_________________________
Work Phone: _________________________

Name of the consulting physician: (please fill out info below if you have a consulting physician in order for us to send a letter to him or her about our assessment)
Name: ____ Fax: _________________________________

Address:____ Phone: ______________________________

Chief Complaint
What is the main reason for your visit to our Allergy and Immunology clinic? How long have you had this problem?

____

____

Please list the approximate dates and findings of any previous allergy testing and evaluation:

____

____

____

If you have received allergy injections in the past, please list the years you received them:

____

____

Patient Name:	DOB:	Chart No.:

Past Medical History

Birth Weight and Gestational Age (40weeks is full term) ____________________

Have you had the following diseases or conditions? (If yes, when did it start?)

	Yes	No	
Illness at birth	___	___	____________
Childhood Illnesses:			
Chicken Pox	___	___	____________
Whooping Cough	___	___	____________
Croup	___	___	____________
High Blood Pressure	___	___	____________
Cataracts or glaucoma	___	___	____________
Thyroid disease	___	___	____________
Heart Disease or arrhythmia	___	___	____________
Heartburn or reflux	___	___	____________
Osteoporosis	___	___	____________
Liver disease	___	___	____________
Kidney disease	___	___	____________

Other medical problems____________________

Infection History

Circle if yes: blood infection, bronchitis, chickenpox (or varicella vaccine), hepatitis, HIV, otitis (ear infections), meningitis, pneumonia, sexually transmitted disease, shingles (zoster), sinusitis, urinary infection, other: ____________

Previous Hospitalizations/Surgeries/ER visits

(Year) **(Procedure or Reason for hospital or ER visit)**

____
____
____
____
____
____
____
____
____

Patient Name: DOB: Chart No.:

Family History

	Mother	Father	Brothr	Sister	Son	Daughtr	Others
• Seasonal allergies(Hay Fever)	_____	_____	_____	_____	_____	_____	_____
• Asthma	_____	_____	_____	_____	_____	_____	_____
• Eczema	_____	_____	_____	_____	_____	_____	_____
• Immune Deficiency	_____	_____	_____	_____	_____	_____	_____
• Other diseases:	_____	_____	_____	_____	_____	_____	_____
(1)____________________	_____	_____	_____	_____	_____	_____	_____
(2)____________________	_____	_____	_____	_____	_____	_____	_____

Social & Environmental History (Please circle when appropriate)

- What pets or animal exposure do you have? For how long? ____
- Do you smoke? YES NO: If Yes, age when you started?____
  If No, have you ever smoked? YES NO Quit?______________________________
- Is there anyone at home who smokes? YES NO Where? INSIDE OUTSIDE
- Do you drink alcohol? YES NO: If Yes, how often and how much? ________________
- How long have you lived at your present address? ________
- Type of home: Single house, Townhouse, Apartment , Mobile Home, Dorm
- Location of home: city, suburb, rural.
- Type of heat: heat pump, baseboard, gas, oil, electric, fireplace, wood-burning stove, kerosene space hearters
- Do you have a : basement or garden apartment, water leak, flood damage, fire damage, excess mold or mildew?
- In the bedroom is there:wall to wall carpet, air conditioning, air filter?
- What type of work do you do (or where do you attend school)? How long have you been involved in this activity?
  ____
- Is your work/school related to the problem you are here for today? Yes No
- How often were you absent from work or school during the last 12 month due to the health problem(s) you are being seen for? __________________________________

Current Medications

(Include all prescribed & over-the-counter medications, vitamins, dietary supplements, antacids, Tylenol, Advil etc.)

NAME	DOSE	HOW MANY TIMES PER DAY	LENGTH OF TIME TAKEN

Name and number of your pharmacy____

Patient Name:	DOB:	Chart No.:

Drugs Allergy: (Please describe briefly any known allergies to drugs in appropriate spaces. If unknown, check appropriate box)

□ Penicillin: ______________________________

□ Sulfa drugs: ______________________________

□ Aspirin, Motrin, Advil, etc (NSAIDS) : ______________________________

□ Other: ______________________________

□ Unknown: (I am unaware of any drug allergies)

Allergy History

Foods:	**Yes**	**No**	**Reaction or Symptoms**:
Nuts	___	___	______________________________
Peanuts	___	___	______________________________
Fish	___	___	______________________________
Shellfish	___	___	______________________________
Milk	___	___	______________________________
Egg	___	___	______________________________
Wheat	___	___	______________________________
Soy	___	___	______________________________
Melon	___	___	______________________________
Banana	___	___	______________________________
Other: ____________________	___	___	______________________________

Animals:	**Yes**	**No**	**Reaction or Symptoms**:
Cats	___	___	______________________________
Dogs	___	___	______________________________
Horses	___	___	______________________________
Insect stings, bites	___	___	______________________________
Other: ____________________	___	___	______________________________

Patient Name:	DOB:	Chart No.:

Allergy History (Continued)

Other Substances	Yes	No	Reaction or Symptoms:
Latex	___	___	___
Nickel, other metal: ___	___	___	___
Poison Ivy	___	___	___
Radiocontrast (IVP) dye	___	___	___
Other: ___	___	___	___

Review of Symptoms

		Yes	No
Constitutional	Have you experienced weight loss?	___	___
	Do you have recurrent unexplained fevers and chills?	___	___
	Do you have night sweats?	___	___
Eyes	Do you have watery or itchy eyes?	___	___
	Do you have burning, redness or discharge?	___	___
ENMT	Do you have ear pain or pressure?	___	___
	Do you have sinus pain or pressure?	___	___
	Do you have loss of smell?	___	___
	Do you have lip swelling or tongue swelling?	___	___
	Do you have soar throat?	___	___
Heart	Do you have skipped beats or palpitations?	___	___
	Do you have chest pain or tightness?	___	___
	Do you have any loss of consciousness or black-outs?	___	___
Respiratory	Do you have a persistent cough?	___	___
	Do you get short of breath easily or wheeze?	___	___
	Have you ever coughed up blood?	___	___
	Do you have shortness of breath?	___	___
	• At rest?	___	___
	• With exercise?	___	___
	• When asleep?	___	___
Gastrointestinal	Do you have heartburn or reflux?	___	___
	Do you have any blood on stools or black tarry stools?	___	___
	Do you have abdominal pain?	___	___
	Do you have vomiting or diarrhea?	___	___
Genitourinary	Do you have painful or unusually frequent urinations?	___	___
	Do you have any blood in urine?	___	___
Musculoskeletal	Do you have any pain or swelling in your joints?	___	___
	Do you have any back pain or muscle aches?	___	___
Skin	Do you have any skin rashes?	___	___
	Do you have any swelling or hives?	___	___
	Do you have any itching?	___	___
	Do you have any dryness or cracking?	___	___

Patient Name:	DOB:	Chart No.:

Review of Symptoms (Continued)

		Yes	No
Neurologic	Do you have migraines or headaches?	____	____
	Do you have any dizziness or ringing in ears?	____	____
	Do you have any visual changes?	____	____
Psychiatric	Are you bothered by depression or anxiety?	____	____
Endocrine	Have you become unusually thirsty recently?	____	____
	Do you sense room temperature differently from others?	____	____
Hematologic/Lymphatic	Do you tend to bruise or bleed easily?	____	____
	Do you feel weak and tired easily?	____	____
	Do you have any swollen lymph nodes?	____	____
Immunologic	Do you get frequent infections requiring antibiotics?	____	____

Patient Signature: ________________________________ **Date:** ____________

(**Please Stop Here**)

Allergy Questionnaire Reviewed by:____ **MD**

Date: _______________________________