



# Allergy & Asthma Centers

Board Certified Pediatric and Adult Allergy & Immunology  
www.AllergyAsthmaDoctors.com

Andrew S. Kim, MD

Ahmed T. Butt, MD

Julie T. Abraham, MD

Seth C. Craig III, MD

1300 Thornton Street, Ste 200  
Fredericksburg, VA 22401  
Ph: 540.371.6810  
Fax: 540.371.9154

9010 Lorton Station Blvd, Ste 210  
Lorton, VA 22079  
Ph: 703.339.1660  
Fax: 703.372.5567

8140 Ashton Ave, Ste 110  
Manassas, VA 20109  
Ph: 703.844.0440  
Fax: 703.844.0445

## Allergy Questionnaire

Date: \_\_\_\_\_

**Please complete this questionnaire 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 problem, but please answer all the questions which pertain to you and your general health. If you have x-rays, CT scans or laboratory tests that relate to your health problem(s), please bring them with you to your appointment or have your doctor send them to our office prior to your appointment.

Please do not take any anti-histamine medications for 5-7 days before your visit for allergy testing. This includes such medications Benadryl (diphenhydramine), Atarax (hydroxyzine), Claritin (loratadine), Zyrtec (cetirizine), Allegra (fexofenadine), Clarinex (desloratadine) and Xyzal (levocetirizine). Many over-the-counter cold, cough and allergy medications also contain anti-histamines. Please feel free to call our office if you are unsure if a medication contains an anti-histamine. If you feel that you **cannot** discontinue your anti-histamine(s) for 5-7 days prior to your visit, please contact our office to let us know before your appointment.

Name: \_\_\_\_\_

Sex: M \_\_\_\_\_ F \_\_\_\_\_

Date of Birth: \_\_\_\_\_

**Consulting Physician** - Please fill out the information below if you have a referring physician.

Doctor's Name: \_\_\_\_\_

Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Fax: \_\_\_\_\_

**Reason for your visit**

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:

\_\_\_\_\_

**Past Medical History**

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

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

**Yes No**

Illness at birth \_\_\_\_\_

Whooping Cough \_\_\_\_\_

Croup \_\_\_\_\_

Diabetes \_\_\_\_\_

High Blood Pressure \_\_\_\_\_

High Cholesterol \_\_\_\_\_

Cataracts or glaucoma \_\_\_\_\_

Thyroid disease \_\_\_\_\_

Heart Disease \_\_\_\_\_

Heartburn or reflux \_\_\_\_\_

Osteoporosis \_\_\_\_\_

Liver disease \_\_\_\_\_

Kidney disease \_\_\_\_\_

Other medical problems not mentioned above: \_\_\_\_\_

**Infection History**

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

Other: \_\_\_\_\_

**Previous Hospitalizations/Surgeries/Emergency Department visits**

**Year**

**Procedure or Reason for hospital or Emergency Department visit**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Drug Allergy:** Please briefly describe any known allergies to drugs below.

Penicillin: \_\_\_\_\_

Sulfa drugs: \_\_\_\_\_

NSAIDs (aspirin, ibuprofen (Motrin, Advil), naproxen, etc.) \_\_\_\_\_

Other: \_\_\_\_\_

None (I am unaware of any drug allergies)

Name:	DOB:	Chart No.:
-------	------	------------



## Allergy History

<b>Foods:</b>	<b>Yes</b>	<b>No</b>	<b>Reaction or Symptoms:</b>
Tree nuts (ex. walnuts, pecans, almonds)	___	___	_____
Peanuts	___	___	_____
Fish	___	___	_____
Shellfish (shrimp, crab, lobster)	___	___	_____
Milk	___	___	_____
Egg	___	___	_____
Wheat	___	___	_____
Soy	___	___	_____
Melons, Bananas	___	___	_____
Apples, Peaches, Cherries	___	___	_____
Other: _____	___	___	_____

<b>Animals/Bee stings:</b>	<b>Yes</b>	<b>No</b>	<b>Reaction or Symptoms:</b>
Cats	___	___	_____
Dogs	___	___	_____
Horses	___	___	_____
Bee Stings (i.e. bees, wasps/hornets, fire ants)	___	___	_____
Other: _____	___	___	_____

<b>Other Substances</b>	<b>Yes</b>	<b>No</b>	<b>Reaction or Symptoms:</b>
Latex	___	___	_____
Nickel, other metal: _____	___	___	_____
Radiocontrast dye	___	___	_____
Other: _____	___	___	_____

## Review of Symptoms

		<b>Yes</b>	<b>No</b>
Constitutional	Have you experienced weight loss?	___	___
	Do you have recurrent unexplained fevers and/or chills?	___	___
Eyes	Do you have watery or itchy eyes?	___	___
	Do you have burning, redness or discharge?	___	___

Name:

DOB:

Chart No.:

**Review of Symptoms, continued****Yes No**

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 a constant sore 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 wheeze?	_____	_____
	Have you ever coughed up blood?	_____	_____
	Do you have shortness of breath?	_____	_____
	<ul style="list-style-type: none"> <li>• At rest?</li> <li>• With exercise?</li> <li>• Wakes you up from sleep?</li> </ul>	_____	_____
Gastrointestinal	Do you have heartburn or reflux?	_____	_____
	Do you have abdominal pain?	_____	_____
	Do you have vomiting or diarrhea?	_____	_____
	Do you have any bloody stools or black tarry stools?	_____	_____
Genitourinary	Do you have painful or unusually frequent urinations?	_____	_____
	Do you have any blood in urine?	_____	_____
Musculoskeletal	Do you have any joint swelling?	_____	_____
	Do you have any joint 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?	_____	_____
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/Parent/Guardian Signature:****Date:****(Please Stop Here)****Allergy Questionnaire Reviewed by: \_\_\_\_\_ MD Date: \_\_\_\_\_**

Name:

DOB:

Chart No.: