Allergy & Asthma Centers

Board Certified Pediatric and Adult Allergy & Immunology

www.AllergyAsthmaDoctors.com

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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 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 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	___	___	______________________________
Croup	___	___	______________________________
Diabetes	___	___	______________________________
High Blood Pressure	___	___	______________________________
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.:

Family History

	Mother	Father	Brother	Sister	Son	Daughter	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? ____
- 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? ___________________________________
- Do you have any: water damage, fire damage or excess mold or mildew?
- In the bedroom, do you have: wall to wall carpeting or wood flooring?
- What type of work do you do? Or, if you are a student, please tell us what grade/level of education:
  ____
- How often were you absent from work or school during the last 12 months 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: DOB: Chart No.:

Allergy History

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

Animals/Bee stings:	**Yes**	**No**	**Reaction or Symptoms**:
Cats	___	___	______________________________
Dogs	___	___	______________________________
Horses	___	___	______________________________
Bee Stings (i.e. bees, wasps/hornets, fire ants)	___	___	______________________________
Other: ____________________	___	___	______________________________

Other Substances	**Yes**	**No**	**Reaction or Symptoms**:
Latex	___	___	______________________________
Nickel, other metal: _______________	___	___	______________________________
Radiocontrast dye	___	___	______________________________
Other: ____________________	___	___	______________________________

Name:	DOB:	Chart No.:

Review of Symptoms, continued

		Yes	No
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?	____	____
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?	____	____
Respiratory	Do you have a persistent cough?	____	____
	Do you wheeze or have chest tightness?	____	____
	Have you ever coughed up blood?	____	____
	Do you have shortness of breath?	____	____
	• At rest?	____	____
	• With exercise?	____	____
	• Wakes you up from sleep?	____	____
Gastrointestinal	Do you have heartburn or reflux?	____	____
	Do you have abdominal pain?	____	____
	Do you have vomiting or diarrhea?	____	____
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?	____	____
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?	____	____
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.: