Allergy & Asthma Center of East Orlando

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Diplomate American Board of Allergy and Immunology

ALLERGY QUESTIONNAIRE

Patient's Name	**Date of Birth**
Date of Appointment	**Referring Physician**

INSTRUCTIONS: **Please answer the questions as they relate to the person being evaluated. A complete, accurate record is important in learning about your allergy problem. Bring this completed form for your first appointment.**

1. HISTORY OF YOUR PRESENT ILLNESS

What is the chief problem that brings you to see the doctor?_____

When did your problem start?_____

How many times has your problem occurred?_____

When was the last time you had problems?_____

When you have a problem, how long does it last?_____

Is it worse at any certain time of day, week or year? (Circle all that apply)

AM PM Weekday Weekend Spring Summer Fall Winter Other_____

Is there anything that seems to trigger your problem? (Circle all that apply)

Grass Dust Mold Cleaning solutions Smoke Perfume A/C Heat Other_____

Is there anything that improves your problem? (Circle all that apply)

Antihistamines Decongestants Nasal steroids Nasal decongestants Oral steroids Antibiotics Albuterol Inhaled steroids Other_____

How severe is your problem when it occurs? **Mild Moderate Severe Very severe**

Are there other associated symptoms that occur?_____

2. SYMPTOMS **Do you have any of the following:**

Runny nose	**YES**	**NO**	**Wheezing**	**YES**	**NO**
Stuffy nose	**YES**	**NO**	**Coughing**	**YES**	**NO**
Post nasal drip	**YES**	**NO**	**Wheezing or coughing with exercise**	**YES**	**NO**
Itchy nose	**YES**	**NO**	**Chest tightness**	**YES**	**NO**
Sneezing	**YES**	**NO**	**Eczema/Rash**	**YES**	**NO**
Itchy eyes	**YES**	**NO**	**Hives**	**YES**	**NO**

3. PAST ALLERGY PROBLEMS **Have you ever had the following conditions?**

			Age of Onset	**Comments**
Asthma **(Wheezing)**	**YES**	**NO**		
Any Other Breathing Problems	**YES**	**NO**		
Sinus Trouble	**YES**	**NO**		
Hay Fever **(Runny, stuffy, itchy nose sneezing)**	**YES**	**NO**		
Hives or Swelling	**YES**	**NO**		
Eczema or Other Rashes	**YES**	**NO**		
Frequent Infections	**YES**	**NO**		
Food Reactions	**YES**	**NO**		
Drug Reactions	**YES**	**NO**		
Insect Reactions	**YES**	**NO**		

Reviewed by: _____ Date:_____

NAME_____

4. RESIDENCE

List your past residences with your most recent first. Only city and state required.

City & State	Effect on Symptoms (better, worse, no change)
1.	
2.	
3.	

5. PREVIOUS ALLERGY EVALUATION AND THERAPY

Have you ever had allergy skin tests? ☐ Yes ☐ No If yes, date _____ Physician's Name _____

Results of these tests: (If possible, please provide us with a copy) _____

Have you ever received allergy injections? ☐ Yes ☐ No If yes, give dates _____

Please list all medications that you are now taking – name, dosage, number of times a day. **Bring all these with you for your first appointment.** _____

Please list all medications you have taken for allergies in the past _____

6. PAST MEDICAL HISTORY

Have you ever had any of the following? Answer all items.

Frequent Otitis Media	**YES**	**NO**	Pneumonia	**YES**	**NO**	Urinary Tract Infection	**YES**	**NO**
Frequent Nosebleeds	**YES**	**NO**	High Blood Pressure	**YES**	**NO**	"Stomach" Ulcers	**YES**	**NO**
Nasal Polyps	**YES**	**NO**	Heart Trouble	**YES**	**NO**	Irritable Bowel Syndrome	**YES**	**NO**
Sinus Surgery	**YES**	**NO**	Diabetes	**YES**	**NO**	Gastroenteritis/Colitis	**YES**	**NO**
Chronic Headaches	**YES**	**NO**	Heartburn/GERD	**YES**	**NO**	Contact Dermatitis	**YES**	**NO**
Hearing Loss	**YES**	**NO**	Hepatitis	**YES**	**NO**	Poison Ivy/Poison Oak	**YES**	**NO**
Glaucoma/Cataracts	**YES**	**NO**	Kidney stones	**YES**	**NO**	Other	**YES**	**NO**
Tonsils Removed	**YES**	**NO**	Chest Xray within last 2 yr	**YES**	**NO**			
Adenoids Removed	**YES**	**NO**	Tuberculosis or other serious lung infection	**YES**	**NO**			
Immunizations up to date?	**YES**	**NO**						

7. BIRTH HISTORY

Complete for patients younger than 12yrs old. ☐ **N/A**

Birth Weight: **APGAR score:** <6 7 8 9 10

Delivery: Complicated Uncomplicated **Route:** Vaginal C-Section Induced

Complications in neonatal period: No Yes **Development:** N/A Normal Delayed

8. SURGERIES

Circle all that apply.

Tonsils	Adenoids	Sinus	Nasal Septal	Cataract	Nasal Turbinate Reduction
C-Section	Hysterectomy	Appendix	Gall Bladder	Other:	

9. ENVIRONMENTAL SURVEY

Where do you live: House Apartment Mobile Home	Occupation:
Main Area Flooring: Carpet Wood Tile	Bedroom Flooring: Carpet Wood Tile
Any pets in the home or regular contact (1x/week or more): Dog Cat Rabbits Gerbils Hamsters Guinea Pig Horses	

Reviewed by: _____ Date: _____

NAME_____

10. FAMILY HISTORY **(e.g. parents, siblings, aunts, uncles, grandparents, first cousins)**

Asthma	**YES**	**NO**	Emphysema	**YES**	**NO**
Hay Fever	**YES**	**NO**	Cystic Fibrosis	**YES**	**NO**
Eczema	**YES**	**NO**	Tuberculosis	**YES**	**NO**
Hives	**YES**	**NO**	Glaucoma	**YES**	**NO**
Swelling	**YES**	**NO**	Diabetes	**YES**	**NO**
Frequent Pneumonia	**YES**	**NO**	Other:	**YES**	**NO**
Headaches	**YES**	**NO**			
Other Allergies	**YES**	**NO**			

11. SOCIAL HISTORY

Marital Status: Single Married Div Widowed Separated | Children: N/A 0 1 2 3 More

Have you ever smoked? Yes No If Yes, how many years? _____

Do you presently smoke? Yes No If No, when did you stop? _____

Average cigarettes per day at highest point? <1/2 pack/day ½ - 1 pack/day 1 pack/day 1 ½ - 2 packs/day >2 packs/day

Are there friends or family who now smoke inside the home? Yes No

Do you drink alcoholic beverages? Yes No

Education (circle highest level completed): Grade school High school College Graduate school Professional Technical

12. REVIEW OF SYSTEMS

Eyes:	Burning	Itching	Discharge	Tearing	Dry Eyes	Vision Decrease (glasses)
Ears:	Ringing	Pain	Pressure	Hearing Decrease	Hearing Correction	
Nose:	Decreased Sense of Smell				
Throat:	Difficulty Swallowing	Pain or Soreness	Tongue Sore or Swollen	Tooth pain	Decreased Taste	
Respiratory:	Cough	Wheezing	Chest Tightness	Pain on Breathing	Shortness of Breath	
Cardiovascular:	Irregular Heartbeat	Rapid Heartbeat	Chest Pain		
Gastrointestinal:	Constipation	Diarrhea	Stomach pain	Cramping pain	Black, tarry or blood in stools	
Genitourinary:	Blood in urine	Difficulty urinating	Frequent urination at night	Pain/Burning on urination	
Musculoskeletal:	Pain in joints	Back Pain	Swelling of Joints	Loss of strength or movement	
Endocrine:	Thyroid Disorder	Diabetes	Menopausal Symptoms		
Hematological:	Easy Bleeding	Anemia	Swollen Glands/Persistent		
Psychiatric:	Depression	Anxiety	Insomnia		
Skin:	Rash	Hives	Itching	Eczema	
Neurological:	Headaches	Weakness	Dizziness	Seizures	

Reviewed by: _____ Date: _____