

SHER ALLERGY SPECIALISTS
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ALLERGY QUESTIONNAIRE

Patient's Name: _____ Date of Birth: _____

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. Please bring this completed form to your first appointment.

1. Briefly, describe the reason for your allergy visit and what you hope to accomplish:

2. PROBLEMS: Have you ever had the following problems or conditions?

Yes	Check all items that apply	Age at onset	Severity Mild, Moderate or Severe
	Asthma		
	Any other breathing problems		
	Sinus trouble		
	Hay Fever (Nasal Allergies)		
	Hives or swelling		
	Eczema or other rashes		
	Frequent infections		
	Food reactions		
	Drug reactions		
	Insect reactions		
	Latex Allergy		
	Metal Allergy		

3. SYMPTOMS: Are you having any of the following? Circle all that apply and indicate frequency

NASAL & SINUS (indicate frequency)

- Runny Nose (One side vs both)
- Stuffy Nose (One side vs both)
- Discolored nasal drainage
- Post Nasal Drip
- Itchy Nose
- Sneezing
- Throat clearing
- Cough
- Hoarseness
- Bad Breath
- Sore throat
- Nose Bleeds
- Nasal Polyps
- Loss or Decrease Sense of Smell
- Mouth Breathing/Snoring
- Sleep Apnea (stop breathing during sleep)
- Sinus X-Rays
- Head or Sinus CT Scan

EYES (indicate frequency)

- Itching
- Redness
- Watery
- Dark Circles
- Dry eyes

CHEST (indicate frequency)

- Cough with Exercise
- Cough with Laughter
- Cough middle of night
- Cough Lying Down
- Cough upon awakening
- Shortness of Breath
- Wheezing
- Chest Tightness
- Nighttime Waking
- Heartburn
- Acid Reflux
- Chest Pain
- Chest X-ray

SKIN (indicate frequency)

- Rash
- Swelling
- Itching
- Bruising
- Dry Skin
- Eczema
- Hives

INFECTIONS (indicate frequency)

- Ear Infections
- Throat Infections
- Sinus Infections
- Pneumonia
- Bronchitis
- Other Infections

HEADACHES

- Frequent headaches
- Severity _____
- Triggers _____
- Pressure
- Unilateral
- Bilateral
- Visual Disturbances
- Nausea
- Vomiting

Are symptoms present year round? _____

Is there a time of year that symptoms are worse? _____

4. MEDICATIONS:

List all medications that you are currently taking (name, strength, number of times a day):

1. _____	6. _____
2. _____	7. _____
3. _____	8. _____
4. _____	9. _____
5. _____	10. _____

List all medication you have taken for allergies in the past:

1. _____	4. _____
2. _____	5. _____
3. _____	6. _____

Do you or have you ever used over the counter nasal sprays? Yes No

If yes, please specify: _____

5. FOOD REACTIONS: Have you ever had any symptoms (rash, hay fever, vomiting, gas, cramps, diarrhea, colic as an infant) after the ingestion of any food, liquid, MSG, Sulfites, or food coloring? If yes please give details below.

FOOD	DATE	SYMPTOMS	Can food be eaten?		DATE FOOD WAS LAST EATEN.
			Yes	No	

6. PRECIPITATING FACTORS/TRIGGERS: For each item below, check the appropriate square to indicate whether symptoms or condition is affected by the following precipitants/trigger.

Condition is made:	WORSE	IMPROVED	NO CHANGE		WORSE	IMPROVED	NO CHANGE
Cutting or playing in grass or raking leaves				Paint lacquer, glue, mothballs, motor fumes, chemicals, fertilizers, insect spray, cooking odors, etc. Specify type:			
High winds, riding in auto				Trips away from home			
Other outdoor exposure				Other strong odors (perfumes, etc) Specify type:			
Mold or mildewed areas				Exposure to animals: Specify:			
Sweeping, dusting or vacuuming				"Colds" or viruses			
Smog, smoking or smoke exposure				Physical exertion or exercise			
Air conditioning or heating				Cold weather			
Cleaning agents, detergents, ammonia, Bleach, soap, conditioner, shaving cream, Toothpastes, etc. Specify:				Other Factors:			

7. RESIDENCE: List your past residents with your most recent first. List only city and state.					
	City & State	How Long	Symptoms better	Symptoms worse	No Change
1.					
2.					
3.					

8. PREVIOUS ALLERGY EVALUATION AND THERAPY

Have you ever had allergy skin tests? Yes No If yes, date (How long ago) _____ Physician's Name: _____

What were the results of these tests: _____

Have you ever received allergy shots? Yes No If yes, give dates: _____

Did your symptoms improve while you received shots? Yes No

Did you ever experience an adverse reaction to an allergy injection? Yes No

If yes, please specify: _____

9. OTHER MEDICAL PROBLEMS: Have you ever been diagnosed with or had any of the following? Circle all that apply

- | | | |
|---------------------|----------------------------|--------------------|
| Hearing Loss | Hepatitis or Liver Trouble | Disruptive Sleep |
| Glaucoma | Frequent Heartburn | Fever |
| Glasses | Frequent Diarrhea | Chills / Sweats |
| Diabetes | Frequent Constipation | Sensitivity to Sun |
| Coughed up blood | Bedwetting | Poison Ivy |
| Tuberculosis | Arthritis | Poison Oak |
| Heart Trouble | Fatigue | Other: _____ |
| High Blood Pressure | Kidney or Bladder Trouble | _____ |

10. WEIGHT: Weight now: _____ Weight one year ago: _____ Maximum weight: _____ When? _____

11. IMMUNIZATIONS: Have you ever experienced any adverse reactions to any immunizations? List dates and reactions, if any.

Tetanus Booster _____ Influenza _____

Pneumovax _____ MMR _____

HIB _____ Prevnar _____

12. BIRTH HISTORY: Please complete the following:

Place of Birth: _____ Age of mother at birth: _____

Was pregnancy normal: Yes No If no, please specify reason: _____

Was delivery by: C-Section Vaginal Patient was: Formula fed breast fed

In the first year of life were any of the following present? Colic Spit up a lot Rash Eczema

Was patient born with pets present in the home? Yes No (If Yes, please list): _____

13. HOSPITALIZATIONS: Please list any surgeries or medical conditions for which you have been hospitalized. (also list dates and doctors)

1. _____

2. _____

3. _____

4. _____

5. _____

14. MARITAL STATUS: Married Single Widowed Separated Divorced Number of Children: _____

15. WORK ENVIRONMENT:

What type of work do you do? _____ Where are you employed? _____

Is your work environment: carpeted tiled Are you exposed to chemicals or strong odors or anything that might aggravate your condition?

If yes, please specify: _____

Are you exposed to smoke? Yes No Are your symptoms worse at work? If yes please specify: _____

Have you missed work because of your allergies? _____ How many days in the last year? _____

16. SCHOOL ENVIRONMENT:

What school do you attend? _____ Is your classroom: carpeted tiled

Is there a problem with mold or mildew? _____

Have you missed school because of your allergies? _____ How many days in the last year? _____

Do you feel school performance has been affected by allergies? _____

17. FAMILY HISTORY: Do any members of your family have a history of allergy?

	Yes	No	(If Yes): List Relationship		Yes	No	(If Yes): List Relationship
Asthma	<input type="checkbox"/>	<input type="checkbox"/>		Cystic Fibrosis	<input type="checkbox"/>	<input type="checkbox"/>	
Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>		Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	
Eczema	<input type="checkbox"/>	<input type="checkbox"/>		Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	
Hives	<input type="checkbox"/>	<input type="checkbox"/>		Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	
Swelling	<input type="checkbox"/>	<input type="checkbox"/>		Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	
Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>		Other: Please Specify _____			
Headaches	<input type="checkbox"/>	<input type="checkbox"/>					
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>					
Lung Disease	<input type="checkbox"/>	<input type="checkbox"/>					

18. ENVIRONMENTAL SURVEY:

Where do you live? <input type="checkbox"/> City <input type="checkbox"/> Rural	Is the home: <input type="checkbox"/> carpeted <input type="checkbox"/> tiled Is bedroom: <input type="checkbox"/> carpeted <input type="checkbox"/> tiled
House construction (brick wood etc.):	How old is your _____ pillow? _____ Mattress?
Approximate age of house:	Is your pillow: <input type="checkbox"/> feather <input type="checkbox"/> foam rubber <input type="checkbox"/> Dacron <input type="checkbox"/> encased in plastic <input type="checkbox"/> other:
Are any rooms damp or musty?	Is your mattress: <input type="checkbox"/> innerspring <input type="checkbox"/> foam rubber <input type="checkbox"/> Waterbed <input type="checkbox"/> encased in plastic <input type="checkbox"/> other:
Type of air conditioning? (central, wall unit etc.):	Are your sheets washed in: <input type="checkbox"/> cold <input type="checkbox"/> warm <input type="checkbox"/> hot water
Type of heating? (electric, gas, central, etc.)	Do you have any: <input type="checkbox"/> Stuffed furniture <input type="checkbox"/> Feather comforters <input type="checkbox"/> stuffed animals
Do you have: <input type="checkbox"/> Air Cleaner <input type="checkbox"/> Air dehumidifier	Do you have pets? (List number and kind. dog, cats, birds, horses etc):
How often do you change/clean your air conditioner and air cleaner filters?	
Number of indoor plants in the home:	Do your pets spend time indoors?
What kind of grass, shrubs and trees are around the home? List:	Other:

19. SELF EVALUATION:

How would you best describe yourself or child?

Timid	Tense
Quiet	Calm
Forward	Few Friends
Aggressive	Well adjusted
Unfriendly	Spoiled
Introvert	Dependent
Independent	Manipulative
Extroverted	Usually ill
Relaxed	Concerned
Happy	Anxious
Many Friends	Shy

20. SMOKING / ALCOHOL / CAFFEINE USE:

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? _____

If you still smoke, do you think you could stop? Yes No Do you or family members smoke In the house In the car

Which other family members now smoke? _____

Do you drink alcohol Yes No If yes, list type: _____

Average weekly consumption (times per week): _____

Do you consume caffeine? Yes No Any other Drug use? Yes No If Yes, Explain: _____