Allergy Questionnaire - Intake Questions

To Be Filled Out by Patient

Patient Name _____ Birthdate _____

Reviewed by _____ Date _____

1. Do you experience any of these symptoms more than twice per year? (Check all that apply)
   - ❑ Cough
   - ❑ Cold
   - ❑ Congestion
   - ❑ Difficulty breathing
   - ❑ Headaches
   - ❑ Wheezing
   - ❑ Runny nose
   - ❑ Sore throat
   - ❑ Itchy/irritated eyes
   - ❑ Sinus pain
   - ❑ Ear pain
   - ❑ Unexplained fatigue
   - ❑ Skin irritation
   - ❑ Snoring

2. Have you ever been diagnosed with asthma or bronchitis? ❑ Yes ❑ No

3. Do you experience symptoms of allergies? ❑ Yes ❑ No

4. Regarding possible food allergies, do you experience any of the following: (check all that apply)
   - ❑ Bloating after eating
   - ❑ Diarrhea
   - ❑ Constipation
   - ❑ Upset stomach
   - ❑ Stomach pain
   - ❑ Indigestion
   - ❑ Nausea
   - ❑ Vomiting
   - ❑ Tingling of the mouth or any other unusual sensation

Allergy Questionnaire - Part 2

To be filled out with allergy counselor after initial screening

1. Of the symptoms (listed on page 1) that you experience during or after eating particular foods, please explain in detail what occurs _____

   _____

2. How often do you experience these symptoms? _____

3. Do you have any of these symptoms?
   - ❑ Unusual Mouth/Tongue sensations
   - ❑ Stomach discomfort
   - ❑ Bowel changes after eating
   - ❑ Unusual itching

4. Which of the following seems to bother you or trigger/cause the above symptoms?

❑ Grass	❑ Cats	❑ Cosmetics	❑ Drafts
❑ Nervousness	❑ Hay	❑ Dogs	❑ Aerosol sprays
❑ House Dust	❑ Cold Air	❑ Mold & Mildew	❑ Horses
❑ Perfumes	❑ Smoke	❑ Humidity	❑ Basements
❑ Other Animals	❑ Insecticides	❑ Pollution	❑ Weather changes
❑ Leaves	❑ Alcoholic beverages	❑ Odors	❑ Exercise
❑ Latex (rubber)	❑ Insect bites/stings. Describe reaction: _____		

   - ❑ Foods. List foods and reactions: _____
   - ❑ Other. List sources and reaction: _____

5. When are your symptoms worst?
   ❑ Year Round ❑ Jan. ❑ Feb. ❑ Mar. ❑ Apr. ❑ May ❑ Jun. ❑ Jul. ❑ Aug. ❑ Sep. ❑ Oct ❑ Nov. ❑ Dec.
6. Are symptoms better away from home? ❑ Yes ❑ No If yes, when? _____
7. Do you have any family history of allergies? Explain _____
8. Have you ever had an allergy skin test or blood test? ❑ Yes ❑ No If yes, results: _____
9. Have you ever had allergy injections? ❑ Yes ❑ No If yes, when? _____
10. Have you received cortisone (prednisone, methylprednisolone, etc.) drugs? ❑ Yes ❑ No
    If yes, when? _____ How much? _____
11. Are you on allergy medications? ❑ Yes ❑ No If yes please list meds, dosing and frequency _____

    _____

    _____
12. What is your occupation? (current or former) _____

OFFICE USE ONLY

Is patient...

- Suffering from uncontrolled asthma
- History of anaphylaxis

IF YES TO ABOVE, REFER OUT TO SPECIALIST

- Required to take beta blockers within 24 hours of test
- Pregnant
- Heavily tattooed
- Significantly immunocompromised or have malignancy or severe chronic illness?

IF YES TO ABOVE, SELECT BLOOD TEST

- Currently taking antihistamine (must be off for 72 hours)
- Wheezing or having difficulty breathing?
- Experiencing active hives, sunburn or extensive dermatitis?

IF YES TO ABOVE, TREAT SYMPTOMS AND SCHEDULE FOR ANOTHER DAY

- Having symptoms consistent with food allergies?

IF YES TO ABOVE, CONSIDER SKIN PANEL AND FOOD PANEL

Indications: Inhalant Panels: ❑ Skin Test ❑ Blood Test **Food Panels:** ❑ Skin Test ❑ Blood Test

Schedule skin test for (date): _____

Patient Name | Birthdate | Reviewed by | Date

Allergy Questionnaire - Part 3

To be filled out by patient during test development

ENVIRONMENTAL SURVEY

1. How long have you lived in your house/apartment? _____
2. Do you live in a ❑ House ❑ Apartment/duplex ❑ Condominium/townhouse
3. Approximately how old is your home? _____
4. Do you live in ❑ City ❑ Suburbs ❑ Rural area
5. Do you have a basement? ❑ Yes ❑ No
6. Type of heating: ❑ hot air ❑ steam (radiator) ❑ electric ❑ hot water (baseboard)
7. Do you have: ❑ Wood /coal stove or fireplace ❑ Humidifier ❑ Dehumidifier ❑ Air cleaner
8. Number of pets (indoor or outdoor) ____Cats ____Dogs ____Birds ____Other
9. Are there any tobacco smokers in your home? ❑ Yes ❑ No
10. Is your bedroom in the basement? ❑ Yes ❑ No
11. Do you have allergy-proof encasing for pillow or mattress? ❑ Yes ❑ No
12. What type of pillows do you have? _____
13. What type of comforter do you have? _____
14. What type of floor covering do you have in your bedroom? ❑ Wall to wall ❑ Area rug ❑ Animal skin ❑ Bare floor
15. How old is your mattress?_____ What's inside your mattress? (i.e. cotton/horse hair)_____
16. Do you have air conditioning? ❑ Yes ❑ No If yes, is it: ❑ Window unit ❑ Central
17. Do you have problems with roaches or mice? ❑ Yes ❑ No
18. Do you have water leaks, mold contamination? ❑ Yes ❑ No
19. Is your home/apartment excessively humid? ❑ Yes ❑ No
20. Do you experience runny nose or sneezing in response to eating? ❑ Yes ❑ No
21. Do you experience runny nose or sneezing in response to strong odors? ❑ Yes ❑ No
22. Do you experience runny nose or sneezing in response to exercise? ❑ Yes ❑ No
23. Do you experience runny nose in response to emotional upset? ❑ Yes ❑ No

MEDICAL HISTORY

1. Check all that apply:

❑ Diabetes	❑ Liver disease/hepatitis	❑ Peptic ulcer	❑ Heartburn/reflux
❑ Cancer	❑ Heart problems/murmur	❑ Thyroid disease	❑ Seizures
❑ High blood pressure	❑ Osteoporosis	❑ Arthritis	❑ Migraines
❑ Anemia/blood disorder	❑ Asthma	❑ Hay fever	❑ Depression
❑ Kidney/bladder disease	❑ Gynecological problems	❑ Diarrhea	❑ Anxiety
❑ Back problems	❑ Glaucoma	❑ Cataracts	❑ Loss of hearing
❑ Emphysema	❑ Eczema		

2. If yes to any of above, please explain: _____
3. If asthmatic, have you ever been hospitalized or incubated? Please explain:_____
   _____
4. Have you had your tonsils or adenoids removed? ❑ Yes ❑ No
5. Have you had ear, nose or sinus surgery? ❑ Yes ❑ No
6. If yes, please explain: _____
7. Who in your family has had: (NOT including yourself)
   ❑ Asthma _____ ❑ Eczema _____
   ❑ Seasonal /year round allergies _____ ❑ Sinus problems _____
   ❑ Other allergies (drugs/bee sting/food etc) _____
8. Do you smoke? ❑ Yes ❑ No If yes, how much?_____
9. Have you smoked in the past? ❑ Yes ❑ No How long ago did you stop? _____
10. How many years did you smoke? _____

Patient Name Birthdate Reviewed by Date