ALLERVISION | *Allergy History Questionnaire*

Patient Name:_____DOB:_____ Date:_____

Do you experience any of the following more than twice per year? (Check all that apply)

__Cough __Cold __Congestion __Wheezing __Runny Nose __Sinus Pain __Skin Irritation
__Headaches __Sore Throat __Ear Pain __Itchy Eyes __Snoring __Ear Popping __Repeated Sneezing
__Unexplained Fatigue __Difficulty Breathing

Have you ever been diagnosed with asthma or bronchitis? __Yes __No

Do you experience symptoms of allergies? __Yes __No

Regarding possible food allergies, do you experience any of the following? (Check all that apply)

__Constipation __Vomiting __Stomach pain __Diarrhea __Indigestion __Upset Stomach __Nausea
__Cough __Wheezing __Tingling feeling of the mouth or tongue __Bloating after eating

Have you had an allergy skin or blood test within the past 3 years? __Yes __No When?_____

Current symptoms you are experiencing:_____
When are your symptoms the worst? __Spring __Summer __Fall __Winter __Year round
Do you have any family history of allergies? __Yes __No Who? __Mother __Father __Sibling __Other
Do you own any pets? __Yes __No __Cat __Dog __Bird __Other:_____
Do you smoke? __Yes __No If yes, how much?_____
What is your current occupation? _____
What do you think are your allergic triggers? _____
Current medications you are taking:_____
Are your current medications relieving your allergy symptoms? __Yes __ No
Explain:_____

Have you ever had anaphylaxis? __Yes __No __Not sure

Have you ever had a reaction to peanuts or bee stings? __Yes __No Which one:_____

If you have asthma, is it under control? __Yes __No How often do you use your inhaler?_____

Are you currently taking Beta Blockers? __Yes __No

Are you pregnant? __Yes __No __ N/A

Are you significantly immunocompromised, have malignancy or severe chronic illness? __Yes __No

Have you taken any antihistamine within the past 72 hours (3 Days)? __Yes __No Type: _____

To the best of my knowledge the information provided above is correct. _____
Patient/Guardian Signature

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Is the patient recommended to have an allergy test? __Yes __No (Skin__ or Blood__) Food Panel__
Patient to test today? __Yes __ No Scheduled for (Date) _____
Refer patient to a specialist. __Yes __No

Reviewed by:_____ Date:_____