# *Allergy Questionnaire - Intake Questions*

**To Be Filled Out by Patient's Parent/Guardian**

Patient Name _____ Birthdate _____

Reviewed by _____ Date _____

1. Does your child 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. Has he/she ever been diagnosed with asthma or bronchitis? ❑ Yes ❑ No

3. Does he/she experience symptoms of allergies? ❑ Yes ❑ No

4. Regarding possible food allergies, does your child experience any of the following? (check all that apply)?
   - ❑ Bloating after eating
   - ❑ Diarrhea
   - ❑ Cough
   - ❑ Constipation
   - ❑ Upset stomach
   - ❑ Wheezing
   - ❑ 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. What symptoms is your child experiencing? (From #1 on intake form) _____

   _____

2. How often does he/she experience these symptoms? _____

3. Does he/she have any of these symptoms?

| | | | |
|---|---|---|---|
| ❑ Cough | ❑ Runny Nose | ❑ Nasal Polyps | ❑ Eczema |
| ❑ Wheezing | ❑ Nasal Congestion | ❑ Poor Sense of Smell | ❑ Hives / Swelling |
| ❑ Shortness of breath | ❑ Itchy Nose | ❑ Ear Infections | ❑ Headaches |
| ❑ Chest tightness | ❑ Itchy / Watery Eyes | ❑ Sinus Infections | ❑ Snoring |
| ❑ Sneezing | ❑ Postnasal Drip | ❑ Blocked Ears | ❑ Fatigue |
| ❑ Phlegm/sputum (Color_____) | | ❑ Other_____ | |

4. Which of the following seems to bother 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 | ❑ Latex (rubber) | ❑ Odors | ❑ Exercise |

   ❑ 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. Has your child ever had an allergy skin test or blood test? ❑ Yes ❑ No If yes, results: _____

9. Has he/she ever had allergy injections? ❑ Yes ❑ No If yes, when? _____

10. Has he/she received cortisone (prednisone, methylprednisolone, etc.) drugs? ❑ Yes ❑ No
    If yes, when? _____ How much? _____

11. Is your child on allergy medications? ❑ Yes ❑ No If yes please list meds, dosing and frequency _____

    _____

    _____

**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 • 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's Parent/Guardian**

## 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 child's bedroom in the basement? ❑ Yes ❑ No
11. Does your child have allergy-proof encasing for pillow or mattress? ❑ Yes ❑ No
12. What type of pillows does he/she have? _____
13. What type of comforter does he/she have? _____
14. What type of floor covering is there in the child's bedroom? ❑ Wall to wall ❑ Area rug ❑ Animal skin ❑ Bare floor
15. How old is the mattress?_____ What's inside the 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. Does your child experience runny nose or sneezing in response to eating? ❑ Yes ❑ No
21. Does your child experience runny nose or sneezing in response to strong odors? ❑ Yes ❑ No
22. Does your child experience runny nose or sneezing in response to exercise? ❑ Yes ❑ No
23. Does your child 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 | ❑ Migraines | ❑ Eczema | ❑ Emphysema |
| ❑ Anemia/blood disorder | ❑ Asthma | ❑ Hay fever | ❑ Depression |
| ❑ Kidney/bladder disease | ❑ Gynecological problems | ❑ Diarrhea | ❑ Anxiety |
| ❑ Back problems | ❑ Glaucoma | ❑ Cataracts | ❑ Loss of hearing |

2. If yes to any of above, please explain: _____
   _____
3. If asthmatic, have you ever been hospitalized or incubated? Please explain:_____
   _____
4. Has your child had tonsils or adenoids removed? ❑ Yes ❑ No
5. Has your child had ear, nose or sinus surgery? ❑ Yes ❑ No
6. If yes, please explain: _____
7. Who in the family has had:
   ❑ Asthma _____ ❑ Eczema _____
   ❑ Seasonal /year round allergies _____ ❑ Sinus problems _____
   ❑ Other allergies (drugs/bee sting/food etc) _____
8. Does anyone in the family smoke? ❑ Yes ❑ No If yes, how much?_____

Patient Name Birthdate Reviewed by Date