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805-777-7676

Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

Allergy Questionnaire reviewed: \_\_\_\_\_

What Problem brings you or your child to this appointment? \_\_\_\_\_

When did symptoms begin? \_\_\_\_\_

Are your symptoms getting worse?  Yes  No

Do you have any of these symptoms? (Please check)

- 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

Check any of the following which seem to trigger (or cause) symptoms or bother you:

- Grass  Cats  Cosmetics  Drafts  Nervousness
- Hay  Dogs  Aerosol sprays  House dust  Cold Air
- Mold and Mildew  Horses  Perfumes  Smoke  Humidity
- Basements  Other animals  Insecticides  Pollution  Weather changes
- Leaves  Alcoholic beverages  Odors  Exercise  Latex (rubber)

Other

When are your symptoms worse?  Year Round

- January  February  March  April  May  June
- July  August  September  October  November  December

Are symptoms better away from home?  Yes  No If Yes, when? \_\_\_\_\_

Have you been skin tested?  Yes  No

Results: \_\_\_\_\_

Have you had allergy injections?  Yes  No When: \_\_\_\_\_

Have you received cortisone (prednisone, methylprednisolone, etc.) drugs?  Yes  No  
When \_\_\_\_\_ How much: \_\_\_\_\_

Occupation (current or former) \_\_\_\_\_

Any harmful exposure at work or school: \_\_\_\_\_

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**ENVIRONMENTAL SURVEY**

How long have you lived in your house/apartment?

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Do you live in a  House  Apartment/Duplex  Condominium/Townhouse  
Approximately how old is your house/apartment/condo?

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Do you live  In the city  In the suburbs  Rural areas

Do you have a basement?  Yes  No

Is your house built on a slab?  Yes  No

Type of heating system (check one)  Hot Air  Steam (radiator)  Electric  Hot water  
(baseboard)

Do you have:  Wood /Coal Stove  Humidifier  Dehumidifier  Air cleaner

Pets (number) – Indoor or Outdoor  None  Cats \_\_\_\_\_  Dogs \_\_\_\_\_  Birds \_\_\_\_\_  Other

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Are there any tobacco smokers in your home?  Yes  No

Is your bedroom in the basement?  Yes  No

Do you have allergy proof encasing for pillow or mattress  Yes  No

What type of pillows do you have? \_\_\_\_\_

What type of comforter do you have? \_\_\_\_\_

What type of floor covering do you have **in your bedroom**?  Wall to wall

Animal skin

Area Rug

Bare floor

How old is your mattress? \_\_\_\_\_ What is in your mattress (i.e. cotton/horse  
hair) \_\_\_\_\_

Do you have air conditioning?  Yes  No If Yes,  Window Unit  Central

Do you have problems with roaches or mice  Yes  No

Do you have water leaks, mold contamination?  Yes  No

Is your home/apartment excessively humid?  Yes  No

If you have any other comments please list it here

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### **YOUR PAST MEDICAL HISTORY**

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  Gynecologic problems  Diarrhea  Anxiety
- Back problems  Glaucoma  Cataracts  Loss of hearing

If yes to any of the above, please explain:  Emphysema

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Have you had your tonsils or adenoids removed?  Yes  No

Have you had ear, nose or sinus surgery  Yes  No

If Yes, please explain

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### **FAMILY HISTORY**

Who in your family has had: (**NOT** including yourself)

- Asthma
- Eczema
- Seasonal /year-round allergies
- Other allergies (drugs/bee sting/food etc.)
- Sinus problems

Please list any hospitalizations regardless of cause:

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List any food allergies and reactions experienced:

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List any drug allergies and reactions experienced (i.e. penicillin, aspirin, sulfa, latex, etc.):

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Describe any reaction to insect stings:

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List all medications and dosages (including nasal sprays, non-allergy medications and alternative/herbal products):

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Do you smoke?  Yes  No How much? \_\_\_\_\_

Have you smoked in the past?  Yes  No When stopped? \_\_\_\_\_

If Yes, how many years have you smoked?

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