Irina Feldman M.D.
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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?
____

Do you live in a □ House □ Apartment/Duplex □ Condominium/Townhouse

Approximately how old is your house/apartment/condo?
____

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
____

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/horsehair) _______________

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: □

____

____

Have you had your tonsils or adenoids removed? □ Yes □ No
Have you had ear, nose or sinus surgery □ Yes □ No
If Yes, please explain

____

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:

____

____

List any food allergies and reactions experienced:

____

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

____

Describe any reaction to insect stings:

____

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

____

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?

____