ALLERGY QUESTIONNAIRE

Introduction: This questionnaire is designed to help us evaluate your allergic symptoms. Please fill out the questionnaire completely. Basically, it asks what you symptoms are, how long you’ve had them, how long you’ve had them, how much they bother you and what has been done in the past to treat them. It is also necessary for us to know your past medical history and family history. There is space for you to add anything else that may be helpful. If you have questions about how to fill out this questionnaire, feel free to ask any member of our staff for help.

DATE: 
NAME: 
AGE: 
DATE OF BIRTH: 
OCCUPATION (or grade): 
REFERRED BY: 

Why are you having (or referred for) an allergy evaluation now and not last year or next?

____________________________________________________________________________
____________________________________________________________________________

Check the ones that apply:

☐ Nose When did nasal symptoms start: 19___/20___
☐ Nasal symptoms worsening ☐ Post nasal drainage (drip in throat)
☐ Runny (☐ clear ☐ discolored) ☐ Itchy nose
☐ Stuffy ☐ Sneezing
☐ Mouth Breather ☐ Decreased or no sense of smell
☐ Snores ☐ Nose Bleeds
How often do symptoms occur:
☐ Daily ☐ 2-3 times a week ☐ Weekly ☐ Monthly
☐ Certain seasons

☐ Eyes ☐ Itch ☐ Watery/Tearing ☐ Red ☐ Puffy/Swollen
☐ Dark circles under eyes

☐ Ears ☐ Fullness ☐ Popping ☐ Itch
☐ Tubes in ears, if so, when______________________________________________

☐ Throat ☐ Frequent throat clearing ☐ Sore throat ☐ Frequent throat infections
☐ Hoarse Voice
☐ Tonsil or Adenoid surgery
When did chest symptoms start: 19__/20__

- Chest symptoms worsening
- Cough
- Sputum (clear discolored)
- Wheezing
- Chest Tightness

Do you wake up at night due to the symptoms:  
- Yes  
- No

How often do symptoms occur:  
- Daily  
- 2-3 times a week  
- Weekly  
- Monthly  
- Only when sick with Upper Respiratory Infection

Do Chest symptoms resolve with use of rescue medicine (Albuterol):  
- Yes  
- No

Have you done a Pulmonary Function Test or Spirometry in the last 2 years:  
- Yes  
- No

Have you been diagnosed with asthma, emphysema, or other breathing problems:  
(Circle or write the answer):___________________________________________

Have you been to the Emergency Room or Hospitalized due to asthma or other breathing problems?  
- Yes  
- No   If so, please explain_________________________________

Check the ones that apply:

<table>
<thead>
<tr>
<th>Awaken because of allergic Symptoms:</th>
<th>□ Nightly</th>
<th>□ 2-3x/week</th>
<th>□ Once/weekly</th>
<th>□ Monthly</th>
<th>□ Never</th>
</tr>
</thead>
<tbody>
<tr>
<td>Boxes of Kleenex per day:</td>
<td>□ Few sheets</td>
<td>□ ¼ Box</td>
<td>□ ½ Box-1 Box</td>
<td>□ 2 or more boxes</td>
<td></td>
</tr>
<tr>
<td>Exercise induced:</td>
<td>□ Cough</td>
<td>□ Wheeze</td>
<td>□ Shortness of breath</td>
<td>□ Chest tightness</td>
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</tr>
<tr>
<td>Do symptoms cause:</td>
<td>□ Fatigue</td>
<td>□ Anxiety</td>
<td>□ Worry</td>
<td>□ Depression</td>
<td>□ Irritability</td>
</tr>
</tbody>
</table>

Days school missed per year (because of allergic symptoms): ____________  
# of nasal symptom free days per week: ____________

Days work missed per year (because of allergic symptoms): ____________  
# of wheeze free days per week: ____________

Physician visits for allergy symptoms in past year: ____________  
Emergency Room visits for allergy symptoms in the past year: ____________
Condition is worse when exposed to: (check all that apply)

- Cats
- Smoke
- Santa Ana winds
- Spring
- Night
- Dogs
- Smog
- Cold air
- Summer
- Day
- Dust
- Perfume
- Change in weather
- Fall
- Indoors
- Grass
- Odors
- Fog
- Winter
- Outdoors
- Other: (please specify)

Do you get Headaches?  ☐ yes  ☐ no

Describe where you feel the pain:

Associated Symptoms with headache

- ☐ Nausea
- ☐ Vomiting
- ☐ Sensitivity to light
- ☐ Sensitivity to sound
- ☐ Have to lay down in a dark room or sleep to feel better

How often do you have headaches:

- ☐ Daily
- ☐ 2-3 time a week
- ☐ Weekly
- ☐ Monthly
- ☐ Change of weather/season
- ☐ Around menses

How long do they last?

List the medications that you are taking now (include allergy and non-allergy medications)

<table>
<thead>
<tr>
<th>MEDICATION</th>
<th># TIMES A DAY</th>
<th>FIRST PRESCRIBED</th>
<th>FOR WHAT CONDITION</th>
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<tbody>
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</table>

Previous Treatment:

Have you seen another Allergist? Name:

date seen:

Results of allergy testing (what are you allergic to):

Did you receive allergy injections (shots):  ☐ yes  ☐ no

Any reactions to the injections?

When was the last injection?

Did the allergy injections help:  ☐ yes  ☐ no

Have you seen an Ear Nose Throat Surgeon? Name:

date seen:

Previous Ear, Nose or Sinus Surgery (if applicable):

Effective:  ☐ yes  ☐ no

When was your last sinus infection:

Did the sinus infection resolve:  ☐ yes  ☐ no

How many sinus infections do you get in a year?

List the last medication to treat the sinus infection:

Have you had a sinus X-ray or CT scan of the sinuses within the last year:  ☐ yes  ☐ no

If so, when/where was it done?

What were the findings?
What medications have you taken in the past or your allergies or asthma

<table>
<thead>
<tr>
<th>MEDICATION</th>
<th># TIMES A DAY</th>
<th>FIRST PRESCRIBED</th>
<th>EFFECTIVE? (Y/N)</th>
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</table>

Other allergic symptoms: (check all that apply)

Skin  
- □ Hives  
- □ Eczema  
- □ swelling

Gastrointestinal  
- □ Nausea  
- □ vomiting  
- □ diarrhea  
- □ heartburn  
- □ acid reflux

Respiratory  
- □ Pneumonia

Drug Reactions:

<table>
<thead>
<tr>
<th>Drug</th>
<th>Type of Reaction</th>
<th>When did it first occur</th>
<th>Was reaction immediate</th>
<th>How long did reaction last</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aspirin</td>
<td></td>
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<td></td>
<td></td>
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<tr>
<td>Penicillin</td>
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<tr>
<td>Sulfa</td>
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<tr>
<td>Other:</td>
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</table>

Food Reactions:

<table>
<thead>
<tr>
<th>Food</th>
<th>Type of Reaction</th>
<th>When did it first occur</th>
<th>Was reaction immediate</th>
<th>How long did reaction last</th>
<th>Can you tolerate now</th>
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</thead>
<tbody>
<tr>
<td>Milk</td>
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<tr>
<td>Egg</td>
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<tr>
<td>Restaurant Meals</td>
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<tr>
<td>Alcohol</td>
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<td>Other:</td>
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</table>

Childhood History (children only):

<table>
<thead>
<tr>
<th>Weeks premature</th>
<th>Complications of pregnancy</th>
<th>Birth weight</th>
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</thead>
<tbody>
<tr>
<td>Nursed</td>
<td>Formula Changes</td>
<td>Newborn</td>
</tr>
<tr>
<td>Diarrhea</td>
<td>Vomiting</td>
<td>Spitting</td>
</tr>
<tr>
<td>Eczema</td>
<td>Colic</td>
<td>Immunizations up to date</td>
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<tr>
<td>Normal development</td>
<td>Daycare</td>
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</tbody>
</table>

Please list all other illnesses (Past and Present):

<table>
<thead>
<tr>
<th>ILLNESS</th>
<th>DATE</th>
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Hospitalizations:

<table>
<thead>
<tr>
<th>REASON FOR HOSPITALIZATION</th>
<th>DATE</th>
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### Female: Reproductive Status

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<th>Date:</th>
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<tbody>
<tr>
<td>Surgically sterile</td>
<td>Tubal ligation</td>
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<tr>
<td>Hysterectomy</td>
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<td></td>
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<tr>
<td>Postmenopausal</td>
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<tr>
<td>Contraception</td>
<td>Type</td>
<td>Date:</td>
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### Environmental Survey:
How long have you live at your current residence _______________ Southern California _______________

<table>
<thead>
<tr>
<th>Prior Residences</th>
<th>Dates</th>
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</table>

What trees are around your house *(list)*:

Please check or complete:
- Water damage to carpeting
- Indoor smoke
- Plastic covers on mattress
- Comforter
- Feather pillow
- Stuffed animals in bedroom
- Air purifier
- Indoor pets *(list, how old?)*

### Family History *(please check)*

<table>
<thead>
<tr>
<th>RELATION</th>
<th>AGES</th>
<th>NASAL ALLERGY</th>
<th>ASTHMA</th>
<th>OTHER ALLERGIC PROBLEM</th>
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If not listed above, please check if you’ve had the following:

- Glaucoma or cataracts
- High blood pressure
- Heart disease
- Irregular heartbeat
- Hepatitis
- Seizures
- Thyroid
- Prostate problems
- Smoke_____ packs/day for_______ years. Date quit_____________
- Never smoked