AZ Allergy and Asthma Specialists

Allergy Questionnaire

Name ______________________________

If you were referred by a physician or patient, there name __________________________

Part 1: Please answer only the sections that apply to you

Age: _______ Sex: Male Female Birthplace: _______________ Years in Arizona _____

Your main concerns: ____

____

Complete this section only for: NOSE /THROAT /EARS/ EYES/ HEAD SYMPTOMS ** If none, skip to next section*

1) Check all that apply **and circle** the ones that bother you the most:

Nose	**Throat**	**Ears**	**Eyes**	**Head**
□ itchy nose	□ sore throat	□ itchy ears	□ itchy eyes	□ headache
□ sneezing	□ itchy throat or palate	□ plugged ears	□ watery eyes	□ facial pressure or pain
□ congestion	□ throat clearing	□ ringing	□ red eyes	
□ decreased smell/taste	□ cough	□ hearing loss	□ dry/irritated eyes	
□ snoring	□ hoarseness		□ swollen lids	
□ runny nose - if yes, is the *nasal discharge:* □ *clear* □ *colored*	□ post-nasal drainage – if yes, is the *drainage:* □ *clear* □ *colored*		□ discharge	

2) When did your symptoms **first** begin? ____________ When, if so, did they **get worse**?__________

3) Are your symptoms: □ seasonal* □ all year long □ all year long, with seasonal worsening*
** Circle the **worst months**:* Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec

4) Check the things that make your symptoms worse:

Irritants	**Weather**	**Medicine**	**Allergens**	**Location**	**Other**
□ smoke	□ cold air	□ aspirin	□ grass	□ outdoors	□ ________
□ air pollution	□ rapid temperature change *(e.g. going from cold outdoors to indoor heat)*	□ non-steroidal anti-inflammatory agents *(e.g. Motrin, Advil, Aleve)*	□ dust or vacuuming	□ indoors	__________
□ fumes or car exhaust			□ damp or musty area	□ daycare	__________
□ strong odors or perfumes			□ animals, if so specify: _______ ________________	□ home	__________
				□ school	__________
				□ work	__________

5) Have you had any of the following **problems** or **procedures**: ** If yes, specify* □ **Yes*** □ No
□ frequent ear infections □ PE tubes □ nasal or sinus surgery □ nasal polyps
□ broken nose □ frequent sinus infections (how many in a year? _______)

Complete this section if: ALLERGIC REACTION TO A STING, DRUG, FOOD or other SUBSTANCE **If none, skip to next section* **If more than one reaction: answer the same questions for each reaction on a separate page**

1) **What** did you react to? ____
If stung, **where** on your body were you stung? ________________________________

2) **When** did the reaction occur? *(date and time of day)* ____________________________

3) **Length of time** from exposure (or sting/injection) until onset of symptoms: ________________

4) **How long** did your symptoms last? ______________________________________

5) Briefly **describe** the reaction: ____

____

____

6) Please check any of the following **symptoms** you had with your reaction:
□ shortness of breath □ tongue swelling □ hoarseness or change in voice
□ dizziness or loss of consciousness □ wheezing or chest tightness □ throat tightness or trouble swallowing
□ flushing □ abdominal cramping, diarrhea or vomiting

7) Did you get **medical attention**? □ **Yes*** □ No
** If yes, was it from:* □ Emergency Room □ Urgent Care □ Clinic □ 911/Medics

8) **Treatment** (if any) you received: ______________________________________

9) Do you have a **current EpiPen**? □ Yes □ No

DO NOT SCAN THIS QUESTIONNAIRE

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Complete this section only for: CHEST or ASTHMA SYMPTOMS **If none, skip to next section*

1) Check all that apply **and circle** the ones that bother you the most:
☐ shortness of breath ☐ wheezing ☐ chest pain or tightness ☐ coughing up blood
☐ recurrent or chronic cough – if yes, is the cough: ☐ wet/productive ☐ dry

2) When did your symptoms **first** begin? ________________ When, if so, did they **get worse**? __________

3) Are your symptoms: ☐ seasonal* ☐ all year long ☐ all year long, with seasonal* worsening?
** Circle **worst months**:* Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec

4) **How often** do you have symptoms? ☐ 2 or less times a week ☐ once a day
☐ 3–6 times a week ☐ throughout the day

5) Do these symptoms **disturb your sleep**? ☐ **Yes*** ☐ No
*If yes, how often? ☐ 2 or less times a month ☐ 3–4 times a month ☐ 2–6 times a week ☐ every night

6) Do your symptoms ever **interfere with exercise** or **daily activities**? ☐ **Yes*** ☐ No
* If yes, what activity? ____

7) Have your symptoms forced you to **miss work** or **school**? *(Circle which one)* ☐ **Yes*** ☐ No
* If yes, how many times in the past 12 months? ________

8) Have your symptoms caused you to go to the **Emergency Room** or **Urgent Care**? ☐ **Yes*** ☐ No
* If yes, how many visits in the past 12 months? _________

9) Have your symptoms caused you to be **admitted** overnight to the hospital? ☐ **Yes*** ☐ No
* If yes, how many times? ____ Were you ever in the Intensive Care Unit? ☐ Yes ☐ No
Have you been intubated or on a ventilator? ☐ Yes ☐ No

10) Have you ever needed treatment with an oral or injectable **steroid**? *(e.g. prednisone)* ☐ **Yes*** ☐ No
* If yes, when was your last course of steroids? ___________________________

11) Check the things that make your **chest symptoms worse**:

Irritants	**Infections**	**Weather**	**Medicine**	**Allergens**	**Location**	**Other**
smoke fumes/car exhaust air pollution strong odors or perfumes	colds or flu sinus infections	cold air weather changes heat	aspirin non-steroidal anti-inflammatory agents *(e.g. Motrin, Advil, Aleve)*	grass dust/vacuuming damp or musty areas animals, If yes, specify: ____________	outdoors indoors home daycare school work: __________	exercise emotion/ stress laughing other: _________

12) Have you ever had pneumonia? ☐ **Yes*** ☐ No * If yes, how many times? _____

13) Have you had a **chest X-ray** since your symptoms began? ☐ **Yes*** ☐ No * If yes, when? ______________

14) Do you have symptoms of **heartburn or acid reflux**? ☐ **Yes*** ☐ No * If yes, how often? ___________

If you've been prescribed albuterol or have asthma, please answer the following questions:

1) How many **puffs** of albuterol do you use **per day**? _____
2) How many **canisters** of albuterol do you use **each month**? _____
3) Do you use a **spacer** with your inhalers? ☐ Yes ☐ No
4) Do you monitor your **peak flows**? ☐ **Yes*** ☐ No
* If yes, what is your **personal best peak flow**? _________
* What has been the **range** of your peak flow readings over the past 2 weeks? ___________

Complete this section only for: ECZEMA **If none, skip to next section*

1) When did your eczema **first** begin? _________________ When, if so, did it **get worse**? ______________

2) What **parts of your body** are most affected? ____

3) Are your symptoms: ☐ seasonal* ☐ all year long ☐ all year long, with seasonal worsening*
Circle **worst months:* Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec

4) Check the things that make your **eczema worse**:

Irritants		**Allergens**		**Foods**			**Other:**
soaps	tight clothing	dust	mold	milk	nuts	soy	Infection
detergents	cosmetics	pollen		wheat	eggs	peanuts	_____________
wool	sun	animals: _________		other: ______________________			
heat							

DO NOT SCAN THIS QUESTIONNAIRE

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Complete this section only for: HIVES or SWELLING **If none, skip to next section*

1) What is your main **problem**? ☐ hives ☐ swelling ☐ hives and swelling
2) What **parts of your body** are affected? ____________________
3) When did your symptoms **first** begin? ____________ When was your **last outbreak**? __________
4) On the average, **how long** does each outbreak last? ________________
5) **How often** do outbreaks occur? daily ___ times a week ___ times a month ___ times a year
6) **If you have hives, how long** does each *individual* hive last? less than 24 hours more than 24 hours
7) Check any **symptoms you have with hives**: ☐ itching ☐ burning ☐ tingling ☐ pain ☐ bruising
8) Check all that apply: Symptoms worse in the: ☐ spring ☐ summer ☐ autumn ☐ winter
Symptoms worse in the: ☐ morning ☐ afternoon ☐ evening ☐ night
Symptoms worse in the: ☐ outdoors ☐ indoors ☐ home ☐ school ☐ daycare ☐ work
Symptoms worse during: ☐ weekdays ☐ weekends ☐ menstrual cycle
9) During an outbreak, do you have any of the following **symptoms**? ☐ **Yes*** ☐ No ** If yes, check box.*
☐ shortness of breath ☐ flushing ☐ tongue swelling ☐ throat tightness or trouble swallowing
☐ wheezing or chest tightness ☐ hoarseness or change in voice ☐ dizziness or loss of consciousness
☐ joint pain ☐ fever ☐ swollen glands ☐ diarrhea, vomiting or abdominal pain
10) Check the things that make your **symptoms worse**:

Exposure to:	**Medicines**	**Allergens**	**Other**
exercise cold air sunlight heat (shower/bath) rubbing or scratching vibration (mowing lawn, motorcycling)	aspirin non-steroidal anti-inflammatory agents (e.g. Motrin, Advil, Aleve) ACE inhibitors (e.g. lisinopril) other medicines: ______	grass dust or vacuuming wooded areas damp or musty area latex (balloons, condoms, dental work, latex gloves) animals, specify: ______ foods or food additives, specify: ______	emotion or stress other: ______

11) Check the box if the following **events** happened soon before your symptoms started:
☐ mononucleosis ☐ jaundice or hepatitis ☐ sore throat or strep throat ☐ sinus infection
☐ swollen lymph glands ☐ urinary tract infection ☐ toothache or gum infection ☐ bee sting
☐ pneumonia ☐ thyroid problems ☐ ulcers or gastritis
☐ fungal infection of skin, scalp, or nails ☐ impetigo or skin infection
☐ transfusion ☐ immunization, specify: ____________________
☐ recent move from another area; from where? ____________________
☐ job change, specify*:* ____________________
☐ change of residence ☐ foreign travel, where? ____________________
☐ other: ____________________

Part 2: Please answer all of the remaining questions

Medicines

List **all** prescription and over-the-counter medicines you're currently taking Include oral, inhaled, injected, drops, sprays, suppositories, creams and ointments.

Name of medicine/dose/frequency	Name of medicine/dose/frequency	Name of medicine/dose/frequency

Allergy History

1) Have you had previous allergy **skin testing**? ☐ **Yes*** ☐ No ** If yes, when?* __________
2) Have you ever received **allergy shots**? ☐ **Yes*** ☐ No ** If yes, specify the years you received them:*
From ______ to _______ Additional years: From ______ to ______ From ______ to ______
Were the shots helpful? ☐ Yes ☐ No Did you have any bad reactions? ☐ Yes ☐ No
3) Do you have allergies to any foods? ☐ **Yes*** ☐ No ** If yes, specify:*

Name of food	Allergic reaction(s)	Approximate date of reaction(s)

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Past Medical History

1) Check the box if you've had any of the following:

☐ glaucoma ☐ cataracts ☐ depression ☐ high blood pressure
☐ diabetes ☐ tuberculosis ☐ positiveTB test ☐ peptic (stomach) ulcer
☐ AIDS or HIV ☐ kidney disease ☐ aseptic necrosis ☐ osteoporosis ☐ heart problems
☐ other significant medical problems: ____

2) Please list all **surgeries and hospital stays:** (followed by approximate date)

__________________________ __________________________ __________________________
__________________________ __________________________ __________________________
__________________________ __________________________ __________________________

3) Have you **ever smoked**? ☐ **Yes*** ☐ No * *If yes, specify.*
Are you: ☐ a **current** smoker? ☐ a **past** smoker? **Quit date:** _____________
What and **how long** did you smoke? ☐ cigarettes: ____ years **Packs per day:** _________
☐ cigars: ___ years ☐ pipe: ___ years

4) Does **anyone** in your home smoke? ☐ **Yes*** ☐ No * *If yes, specify.*
☐ mother ☐ father ☐ spouse or partner ☐ son ☐ daughter
☐ brother ☐ sister ☐ roommate ☐ other: ____________________

Family History

Please place a number for each relative with the following medical problems:

Medical Problem	Mother	Father	Brother	Sister	Son	Daughter	Grandmother	Grandfather
Asthma								
Emphysema								
Nasal allergy								
Sinus problems								
Eczema								

Environmental History

1) What is/was your **occupation** or, if you are still a student, your **grade** in school? ________________
2) What are your **hobbies**? ____
3) **How long** have you lived at your present location? ______ years
4) **Location**: ☐ downtown urban suburb rural/country
5) **Type of home**: ☐ house apartment/condo mobile home
6) **Where** do you live? *(City, town, city neighborhood, or nearest city)?* ______________________________
7) **Type of heating**: radiant forced air heat pump wood burning stove
8) **Air conditioning**: ☐ none central window units Evaporative Cooler
9) **Air filter**: ☐ HEPA electrostatic
10) **Floor**: Bedroom: ☐ carpeting ☐ wood/laminate ☐ tile ☐ cement ☐ other: ___________
Family room: ☐ carpeting ☐ wood/laminate ☐ tile ☐ cement ☐ other: ___________
11) **Mattress**: ☐ regular ☐ foam ☐ air mattress ☐ waterbed ☐ futon ☐ other: ___________
12) **Pillow**: ☐ synthetic ☐ foam ☐ down ☐ feather ☐ cotton ☐ other: ___________
13) **Comforter**: ☐ none ☐ down ☐ synthetic ☐ feather ☐ other: _____________________
14) Do you have zippered dustmite **allergy covers (encasements)**? ☐ **Yes*** ☐ No * *If yes, what item is covered?*
☐ pillows ☐ mattress ☐ comforter ☐ box springs
15) Do you have any **pets**? ☐ **Yes*** ☐ No * *If yes, check all that apply and how many of each animal.*
☐ cat(s) #___ ☐ dog(s) #___ ☐ bird(s) #___ ☐ guinea pig(s) #___
☐ gerbil(s) #___ ☐ hamster(s) #___ ☐ rabbit(s) #___ ☐ other: _________________
Circle all pets that live in or have access to your (or the patient's) bedroom.
16) Do you have a **mold** or **mildew** problem in your home? ☐ Yes* ☐ No *If yes, is it a ☐ minor problem? ☐ major problem?
Where is it? ☐ bathroom ☐ basement ☐ kitchen ☐ window sills ☐ other: ______________________

Thank you