Allergy Questionnaire

Don't Panic! This won't take long and you know all the answers.

Patient's Name: **Age:**

Were you referred by another doctor? ❑Yes ❑No Name: _____

If you could fix one thing about your allergies, what would it be? _____

Please check all recurrent symptoms.

Nasal Symptoms:	**Sinus Symptoms:**	**Chest/Throat Symptoms:**	**Skin Symptoms:**
❑ Runny nose	❑ Post nasal drainage	❑ Wheezing	❑ Itching
❑ Nasal congestion	❑ Frequent throat clearing	❑ Chest tightness	❑ Eczema
❑ Sneezing	❑ Sinus pressure	❑ Shortness of breath	❑ Hives
❑ Itchy eyes	❑ Headache	❑ Cough	❑ Swelling
❑ Watery eyes	❑ Colored nasal mucous	❑ Wheezing with exercise	❑ Blisters
❑ Itchy nose	❑ Stuffy ears	❑ Difficulty breathing at night	❑ Contact allergy
❑ Itchy ears	❑ Frequent sinus infections	❑ Frequent pneumonia	❑ Other
❑ Itchy throat	❑ Bad breath	❑ Throat tightness	_____
❑ Decreased taste or smell	❑ Snoring	❑ Hoarse voice	_____

How long have you had these symptoms?

Nasal _____ Sinus _____ Chest _____ Skin _____

How often do the symptoms occur? (constant, daily, weekly, monthly, off-and-on)

Nasal _____ Sinus _____ Chest _____ Skin _____

Is there any **seasonal variation** in your symptoms and if so, when are they worse? ❑Yes ❑No

Nasal _____ Sinus _____ Chest _____ Skin _____

What **medications** have you tried for your allergy symptoms? Circle the ones that have helped.

_____

_____

What **environmental triggers** have made your symptoms worse? ❑ Mowed grass ❑ Windy weather ❑ Dust ❑ Spending time out of doors ❑ Moldy places ❑ Sweeping or dusting ❑ Cigarette smoke ❑ Pollen ❑ Insect sting ❑ Exercise ❑ Respiratory infections ❑ Weather changes ❑ Laughing ❑ Cold Air ❑ Nighttime ❑ Stressful events ❑ Animals (specify) _____ ❑ Perfumes, cosmetics, odors, etc. (specify) _____

Have you had a **sinus CT**? ❑Yes ❑No When?/Results _____

Other physicians seen for this problem? ❑ ENT ❑ Pulmonologist ❑ Dermatologist ❑ Gastroenterologist

Have you had nasal or **sinus surgery**? ❑Yes ❑No When?/Results _____

Have you been treated in **urgent care or ER** with asthma? ❑Yes ❑No Last visit _____

Have you had **allergy tests**? ❑Yes ❑No When/where? _____

Have you had **allergy shots**? ❑Yes ❑No When/where? _____

Your Environment

How long have you lived in Arizona? _____ **Where else** have you lived? _____

_____ Are you **better or worse** in Az? Better ❑ Worse ❑

Any pets? ❑Yes ❑No Please List _____

Are **symptoms worse** when around your pet? Yes ❑ No ❑ Any **previous pets** in the home? ❑Yes ❑No

Any **smokers** in the home? ❑Yes ❑No Does your home have a **swamp cooler**? ❑Yes ❑No

Type of Home: ❑ Appartment/Condo. ❑ House Has your home had **water or flood damage** ❑Yes ❑No

What kind of work do you do? _____ Are symptoms worse at work? ❑Yes ❑No

Have you **travelled out of the country** in the past year? ❑Yes ❑No Where? _____

Are there **other households** you visit frequently? ❑Yes ❑No Explain: _____

Family members with allergies/asthma? ❑ Mother_____ ❑ Father _____ ❑ Siblings _____

Please list **all current medications** including inhalers, over the counter medications, vitamins, and supplements

_____

_____

_____

_____

Any **medications that you do not tolerate**? ❑Yes ❑No If yes, list the medications and the reaction they caused

_____

_____

_____

Any **foods that you do not tolerate** ❑Yes ❑No If yes, list the foods and the reaction they cause

_____

_____

Medical History (check all that apply)

❑ Cataracts	❑ High blood pressure	❑ Acid reflux	❑ Stroke
❑ Glaucoma	❑ Coronary artery disease	❑ Irritable bowel	❑ Migraine headaches
❑ Hearing loss	❑ Irregular heart beat	❑ Inflammatory bowel disease	❑ Seizure disorder
❑ Frequent nose bleeds	❑ Enlarged heart	❑ Diabetes	❑ Kidney disease
❑ Nasal polyps	❑ Lung disease	❑ Thyroid disorder	❑ Cancer
❑ Ear tubes	❑ Sleep apnea	❑ Pituitary disorder	❑ Arthritis
Other_____	Other_____	Other_____	❑ Osteoporosis

Social History

Do you now or have you ever **smoked**? ❑Yes ❑No How much/ how long? _____

Additional information you would like to mention: