

ALLERGY HISTORY QUESTIONNAIRE

Name: _____ Date: _____

Occupation: _____

Have you ever been tested for allergies? Yes No If yes, please answer the following:

By whom? _____

Were you found to be allergic? Yes No

To what? _____

Were you treated with allergy shots? Yes No

For how long? _____

Did the treatment help? Yes No

Section One – Symptoms

What are the main symptoms that brought you to the doctor? _____

How long have these symptoms lasted? _____

Did anything initiate the symptoms? _____

Does anything make the symptoms better or worse? _____

Are your symptoms worse in: Spring Summer Winter Fall

Please check the conditions below which apply to your symptoms:

A. Symptoms of Pollen Allergy

- Worse outdoors
- Worse on windy days
- Worse on sunny days
- Itching eyes
- Worse outdoors 7:00 to 11:00 am
- Better indoors
- Improved in air conditioning

B. Symptoms of Dust Allergy

- Worse indoors
- Improved outdoors
- Increased after going to bed or at night
- Recur or increase each year with the return of cold weather
- Nasal symptoms with little or no itching of the eyes
- Worse with air conditioning
- Increased in dust (such as in dusting or sweeping)
- Increased on exposure to cold air

C. Symptoms of Mold Allergy

- Worse outdoors between 4:30 and 8:30 pm
- Increased by cool evening air
- Worse while mowing or playing on grass
- Worse from mid-July to November
- Worse at damp or low places
- Distinctly aggravated in fall, winter
- Worse in coastal areas
- Worse on rainy days

D. Symptoms from Specific Contacts

- Worse in house after lights have been on an hour
- Worse in certain rooms: Which ones? _____
- Worse in basement
- Worse around feed mills or barn
- React in a home with cats
- React in a home with dogs
- Worse in your house, but not in others
- Increased by drinking water

Please check any symptoms you are experiencing:

A. Respiratory

1. General

- Pain
- Nose bleeds
- Loss of weight
- Night Sweats
- Temperature elevation
- Tonsillitis
- Frequent colds
- Fatigue
- Difficulty sleeping

2. Nasal Symptoms

- Runny nose
- Itching
- Congestion
 - Intermittent
 - Constant
 - Daytime
 - Nighttime
 - After meals
 - With temperature change
 - Seasonal: Which ones? _____
 - Year-round

3. Cough

- Seasonal
- Year-round
- Particular time of day
 - _____ am
 - _____ pm
- Worse after colds
 - Productive
 - Color _____
- Consistency _____

4. Sneezing

- Seasonal
- Year-round
- Upon waking up
- At meals
- After meals
- In dust
- In smoke

5. Breathing

- Noisy
- Wheezing
 - Daytime only
 - Nighttime only
 - Anytime
 - With exercise only

6. Voice

- Hoarse
 - Intermittent
 - Constant
 - Worse as day progresses
- Frequent laryngitis

B. Gastrointestinal

1. Mouth

- Sore lips
- Sore mouth
- Sore tongue
- Roof itches
- Lip swelling

2. Stomach

- Retasting food
- Nausea
- Vomiting
- Cramps
- Bloating

3. Throat

- Sore
- Scratchy
- Lump in throat
- Difficulty swallowing

4. Rectal

- Itching
- Pain

5. Appetite

- Good
- Selective
- Poor

C. Cardiovascular

1. Shortness of Breath

- Daytime
- Nighttime
- With exercise
- # of Pillows for sleep? _____

2. Swelling

- Face
- Hands
- Legs
- Time of day? _____

3. High Blood Pressure

4. Chest Pain

5. Heart or Pulse Irregular

6. Previous Heart Disease

D. Neurological

1. Headaches

- Age at onset _____
- Duration _____
- Frequency
 - Regular
 - Irregular
 - At menses only
- Migraine

2. Fatigue

- Upon waking up
- After meals
- Without exercise
- Constant

3. Ears

- Tinnitus or ear ringing
- Vertigo or dizziness
 - Seasonal: Which ones? _____
 - Year-round
 - After eating: What foods? _____
 - With weather change
 - On windy days
 - On overcast days
- Frequent infections
- Fluid behind eardrums
- Drainage

- Meniere's disease
- Hearing fluctuation
 - Seasonal: Which ones? _____
 - Year-round
 - After eating: What foods? _____
 - With weather change
 - On windy days
 - On overcast days
- Hearing loss: Which ears? _____
- Ear fullness or pressure
- Problems changing altitude

E. Musculoskeletal

1. Aching Muscles
2. Joint Pain
 - Continuous
 - Intermittent
 - After meals
 - Seasonal
3. Arthritis
4. Bursitis

F. Genitourinary

1. Urination
 - Painful
 - Delayed
 - Prolonged
 - Frequent
 - Daytime
 - Nighttime
 - Bed Wetting

G. Skin

1. Rash
 - Duration _____
 - Location
 - Generalized (all over)
 - Localized: Where? _____
2. Eczema (dry, scaly skin)
3. Fungal Infection (nails, skin)

H. General

- Pain
- Night sweats
- Frequent colds
- Difficulty sleeping
- Nose bleeds
- Temperature elevation
- Fatigue
- Watery eyes

- Loss of weight
- Tonsillitis
- Fatigue
- Itchy eyes

Section Two – Environmental Exposures

A. Home

1. Type

- Single house
- Duplex
- Apartment: Floor? _____
- Hotel
- Trailer

2. Details

- Slab foundation
- Crawl Space
- Basement
- Papered walls
- Sheet rock
- Garage: Attached? _____

3. Region

- City, industrial
- City, residential
- Suburban
- Small town
- Rural

4. Heating and Ventilation

- Central Heat
 - Gas
 - Electric
- Central Air

5. Washer and Dryer

- Washer: Location? _____
- Dryer: Location? _____
 - Gas
 - Electric

6. Other

- Indoor plants: Location? _____
 - Types? _____
- Fireplace
 - Wood Gas
- Feather or down pillows / comforter

C. Animals and Birds

- Dog # _____
 Cat # _____
 Birds # _____
 Gerbil, hamster, mouse, etc. # _____
 Horse # _____
 Other # _____

D. Food

- Vegetarian
 Eat organic only
 On a diet: Type? _____
 Food cravings (describe) _____
 Food sensitivities or reactions (list food and type of reaction) _____

D. Work

- Describe your work location: _____
- Symptoms worse at work
 Symptoms improved at work
 Foul odors or chemicals at work (describe) _____

Section Three – Family History

Please indicate if any of your family members have had any of the following health problems:

	Father	Mother	Brother	Sister	Child
Hay Fever					
Asthma					
Hives					
Eczema					
Food Allergies					
Sinus Problems					
Thyroid Problems					
Emphysema					
Diabetes					
Heart Problems					
Cancer					

Section Four – General Medical History

Please circle any of the following medical conditions you are experiencing, or have experienced in the past:

- | | | | |
|---------------------|-----------------|----------------|-------------------------------|
| High blood pressure | Heart disease | Heart attack | Arthritis |
| Sinus disease | Bronchitis | Emphysema | Asthma |
| Hay Fever | Nasal polyps | Ulcers | Stomach or intestinal disease |
| Thyroid dysfunction | Seizures | Headaches | Migraines |
| Hives | Skin disease | Food allergies | Cancer |
| Fibromyalgia | Chronic fatigue | Diabetes | |

Please list all current prescription medications and dosages: _____

Please list all current supplements (vitamins, minerals, etc.) and herbs: _____

Have you ever had a bad reaction to a medication? Yes No If yes, please list the medication and reaction:

Do you smoke? Yes No If yes, what do you smoke and how much? _____

Do you drink alcohol? Yes No If yes, what type and how much? _____

Stopped smoking in _____ Stopped drinking in _____

Emergency Contact Information:

Name _____ Relationship to Patient _____

Contact Phone: _____