NEW PATIENT ALLERGY QUESTIONNAIRE

Information provided by this questionnaire will be of major assistance to the doctor in helping you. Please take the time to complete this questionnaire (it takes only 10-15 minutes) before your appointment. Base your answers on your own observations and not what you have been told by others or what you may have by others or what you may have presumed based on the basis of previous allergy tests.

Gender: ☐ Male ☐ Female

Patient Name:_____ Date:_____

Home Address:_____ Date of Birth:_____

City, State, Zip:_____

Work #:_____ Home #_____ Cell/Pager# _____

Primary Care Physician_____

Referring Physician_____

Insurance_____

I. Major Reason for Referral

☐ Hayfever or "sinus" ☐ Hives or swelling

☐ Insect sting reaction ☐ Food allergy

☐ Eye problems ☐ Eczema or other rash

☐ Drug reaction ☐ Recurrent infections

☐ Asthma or chronic cough ☐ Headaches

☐ Intestinal problem ☐ Other_____

II. **Please describe** in your own words the problem(s) that you are having which you think might be on a basis of an allergic reaction.

_____

_____

_____

_____

III. Symptom History

A. How long have you had your symptoms?_____

B. Are they getting worse? Yes No

C. Are your symptoms (check one):

Present all year but worse at certain times of the year?

Coming and going without apparent relation to the time of the year?

Only at certain times of the year?

D. Circle the months you are worse:

JAN FEB MAR APR MAY JUN JUL AUG SEP OCT NOV DEC

E. Do you have to miss school or work because of allergy symptoms?

No Occasionally Frequently

F. Do your symptoms disturb your sleep?

No Occasionally Frequently

G. Are your worse (circle):

indoors, outdoors, at home, at work, mornings, or evenings

IV. Symptom Review (circle all appropriate answers)

A. Eye Symptoms: none, itching, watering, redness, swelling, crusting, dryness, burning, dark circles, blurred vision, wear contact lenses, other_____

B. Ear Symptoms: none, itching, popping, congested, frequent infections, fluid in middle ear, PE tubes, hearing loss, earache, dizziness, other_____

C. Nasal Symptoms: none, sneezing, itching, sniffles, watery discharge, cloudy discharge, congestion, frequent nosebleeds, broken nose, loss of sense of smell/taste, polyps, frequent sinus infections, nasal dryness, snoring at night, other_____

D. Mouth and throat symptoms: none, frequent sore throats, hoarseness, itchy throat, difficulty swallowing, swollen neck glands, mouth breathing, frequent strep throat, frequent tonsillitis, postnasal drip, other_____

E. Headaches: infrequent, occasional, frequent, occur with sinus symptoms, sharp, dull, pounding, facial, forehead, temples,
back of head, migraine, other_____

F. Chest symptoms: none, chronic cough, chest tightness/congestion, wheezing, shortness of breath, wheeze/cough after exercise, sputum production, chest pain or soreness.

Has asthma been previously diagnosed? Yes No

Frequent pneumonias? Yes No

Abnormal chest x-ray? Yes No have not had chest x-ray

Other_____

G. Stomach/Intestinal symptoms: none, nausea and vomiting, bloating, loss of appetite, abdominal pain or cramping, diarrhea frequently, constipation frequently, pain, or difficulty swallowing, heartburn or indigestion, other_____

H. Skin symptoms: none, dry skin, hives, swelling, itchy skin, eczema, poison ivy/oak allergy, skin sensitivity to metals, chemicals, cosmetics, other_____

I. Insect sting reaction:

none, large swelling, hives, difficulty breathing, throat swelling, dizzy, other_____

Stung by: bee, fire ant, other_____

V. Allergy Symptom Triggers **Which of the following do you think cause or make your symptoms worse. Please check appropriate boxes.**

Trigger	Nose/Sinus Eyes/Ears Symptoms	Asthma/ Bronchitis Symptoms	Hives/ Eczema Symptoms	Stomach/ Intestinal Symptoms	Other
parks/fields					
mowed grass					
gardening					
house dust					
weather changes					
windy days					
humid days					
hot days					
cold days					
air conditioning					
forced air/heat					
drafts					
tobacco smoke					
fumes/aerosols/sprays					
cosmetics/perfumes					
chemicals					
soap powder					
newspaper print					
pets/animal exposure					
exercise					
tension/excitement					
clothing/fabrics					
medicines (which)					
milk/dairy products					
beer/wines					
certain foods (list)					
Menstrual periods					
other					

Comments/explanation:_____
_____
_____
_____

VI. Treatment

A. List medications you have used to treat allergy symptoms (circle those that were helpful):
_____
_____
_____

B. Side effects from medications: none, drowsiness, irritation or nervousness, insomnia, other_____

C. Do you use over-the-counter nasal sprays or drops? Yes No

If yes, how often?_____

D. Have you taken cortisone (by injection or mouth) in the past two years? Yes No

E. Have you been on any special allergy diets? Yes No

F. Have you been tested for allergy previously? Yes No

If yes, when and where_____

Did you have positive reactions to: (circle) pollen, dust, animal dander, molds, foods, other_____**, no reactions.**

G. Have you been on allergy shots before? Yes No

If yes, when, where, and for how long?_____
_____

Were they helpful? Yes No Not sure

H. Did you have a serious reaction to allergy testing or allergy shots? Yes No

VII. Past Medical History

A. Have you had an allergic reaction to any medications? Yes No

If yes, please list_____

B. Please list medications (other than allergy medicines) that you take regularly:_____
_____

C. Previous hospitalizations for allergy problems? Yes No

If yes, please list_____
_____

D. Surgery that you had (circle): none, tonsillectomy, adenoidectomy, nasal septum repair, sinus surgery, tubes in ears, removal of nasal polyps, chest surgery.

E. Infancy-Early childhood problems (circle) none, milk allergy, formula changes, food allergy, colic, frequent diarrhea, ,frequent constipation, vomiting, frequent skin rashes, bronchiolitis, frequent bronchitis, asthma, eczema.

F. If patient is a child, has growth and development been normal? Yes No

G. Immunizations: severe or unusual reactions? Yes No

VIII. Review of Systems

A. Would you describe your general health as: excellent, good, fair, poor.
B. Other medical problems (circle): none, high blood pressure, heart disease, diabetes, emphysema, anemia, liver disease, jaundice, arthritis, intestinal disorders, TB, kidney disease, migraine, epilepsy (seizures), attention deficit disorder, cancer, prostrate trouble, thyroid trouble, glaucoma, fatigue, ulcers, sleep difficulty, frequent depression, irritability, other_____
C. Psychological Factors: nervous tension: little considerable
financial problems: minor major
work or school adjustment: easy difficult
marital adjustment: easy difficult
D. Smoking History Yes No
If yes, amount _____how long_____
When did you quit?_____
E. Women of childbearing age: Are you pregnant, trying to conceive, or nursing a baby? Yes No

IX. Family History

A. Which family members (including grandparents, aunts, uncles) have hayfever or "sinus"?
_____
Which have asthma?_____
Do any family members have (circle): hives or swelling, eczema, food allergy, drug allergy, insect allergy, emphysema, cystic fibrosis, TB diabetes, serious infections, death in infancy.

X. Environmental Survey

A. Residence
1. How long have you lived in Central Texas?_____
2. Other areas of residence and dates:
_____
_____
_____
3. Do you live in a (circle): house, apartment, mobile home, other_____
Age of home_____How long at present address_____
4. Home located in or near (circle): residential area, open fields, factory, lakes
5. What type of grasses, trees, and shrubs are in your neighborhood?_____
_____
_____
6. Is your home air conditioned? Yes No if yes, central or window? Fans? Yes No
7.Is your home heated? (circle) central, wall, space heaters, fireplace
8.Do you have pets at home? Yes No
If yes, (circle) dog, cat, birds, hamsters, other_____
Do the pets spend time indoors? Yes No N/A
In the bedroom? Yes No N/A
List other pets your are exposed to regularly _____
How long have you had pets?_____

9. Are there smokers at home? Yes No If yes, how many?_____
10. In patient's bedroom, are there (circle): plants, stuffed toys, carpet, rugs, down comforters, pillows, (feather, foam or synthetic?), drapes, blinds, bookshelves, bunk beds, humidifiers/vaporizers.

B. Occupation/Hobbies
1. Current occupation:_____
If patient is a child, parents' occupation(s)_____
2. Previous occupation(s):_____ _____
3. Are you exposed to anything at work or school that might aggravate your condition? Yes No If yes, what_____
4. Hobbies (circle): sewing, gardening, cooking, painting, sports, photography, other_____
_____
5. If patient is a child, is he or she in daycare? Yes No

- **Thank you very much for taking the time to fill out this questionnaire.**
- **The doctor will review this questionnaire before seeing you.**