

# 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
- Nasal congestion
- Sneezing
- Itchy eyes
- Watery eyes
- Itchy nose
- Itchy ears
- Itchy throat
- Decreased taste or smell

- Post nasal drainage
- Frequent throat clearing
- Sinus pressure
- Headache
- Colored nasal mucous
- Stuffy ears
- Frequent sinus infections
- Bad breath
- Snoring

- Wheezing
- Chest tightness
- Shortness of breath
- Cough
- Wheezing with exercise
- Difficulty breathing at night
- Frequent pneumonia
- Throat tightness
- Hoarse voice

- Itching
- Eczema
- Hives
- Swelling
- Blisters
- Contact allergy
- Other \_\_\_\_\_
- \_\_\_\_\_

**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:**  Apartment/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

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

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

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## Medical History (check all that apply)

- |   |  |   |   |
|---|--|---|---|
| <input type="checkbox"/> Cataracts            | <input type="checkbox"/> High blood pressure     | <input type="checkbox"/> Acid reflux                | <input type="checkbox"/> Stroke             |
| <input type="checkbox"/> Glaucoma             | <input type="checkbox"/> Coronary artery disease | <input type="checkbox"/> Irritable bowel            | <input type="checkbox"/> Migraine headaches |
| <input type="checkbox"/> Hearing loss         | <input type="checkbox"/> Irregular heart beat    | <input type="checkbox"/> Inflammatory bowel disease | <input type="checkbox"/> Seizure disorder   |
| <input type="checkbox"/> Frequent nose bleeds | <input type="checkbox"/> Enlarged heart          | <input type="checkbox"/> Diabetes                   | <input type="checkbox"/> Kidney disease     |
| <input type="checkbox"/> Nasal polyps         | <input type="checkbox"/> Lung disease            | <input type="checkbox"/> Thyroid disorder           | <input type="checkbox"/> Cancer             |
| <input type="checkbox"/> Ear tubes            | <input type="checkbox"/> Sleep apnea             | <input type="checkbox"/> Pituitary disorder         | <input type="checkbox"/> Arthritis          |
| Other _____                                   | Other _____                                      | Other _____   | <input type="checkbox"/> Osteoporosis       |

## Social History

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

Additional information you would like to mention: