ALLERGY AND IMMUNOLOGY QUESTIONNAIRE

PATIENT NAME

DATE

OCCUPATION

AGE

Please check your symptoms and complaints:

<table>
<thead>
<tr>
<th>CHEST</th>
<th>NOSE</th>
<th>EARS</th>
<th>EYES</th>
<th>THROAT</th>
<th>SKIN</th>
<th>OTHER</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Asthma</td>
<td>☐ Hay fever</td>
<td>☐ Itching</td>
<td>☐ Itching</td>
<td>☐ Itching</td>
<td>☐ Itching</td>
<td>☐ Headache</td>
</tr>
<tr>
<td>☐ Cough</td>
<td>☐ Congestion</td>
<td>☐ Blockage</td>
<td>☐ Tearing</td>
<td>☐ Hoarseness</td>
<td>☐ Hives</td>
<td>☐ ________</td>
</tr>
<tr>
<td>☐ Wheeze</td>
<td>☐ Sneezing</td>
<td>☐ Frequent infection</td>
<td>☐ Swelling</td>
<td>☐ Frequent infection</td>
<td>☐ Eczema</td>
<td>☐ ________</td>
</tr>
<tr>
<td>☐ Tightness</td>
<td>☐ Running</td>
<td>☐ Redness</td>
<td>☐ Post nasal drip</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐ Shortness of breath</td>
<td>☐ Itching</td>
<td></td>
<td></td>
<td>☐ Soreness</td>
<td>☐ Dryness</td>
<td>☐ ________</td>
</tr>
<tr>
<td>☐ Frequent infections</td>
<td>☐ Polyps</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐ Congestion</td>
<td>☐ Loss of smell</td>
<td></td>
<td></td>
<td>☐ Redness</td>
<td></td>
<td></td>
</tr>
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</tr>
</tbody>
</table>

Which symptoms cause you the most concern?
________________________________________________________________________
________________________________________________________________________

When did your symptoms begin? Month Year

In what city or area were you when you first experienced your symptoms?

Are your symptoms worse any season of the year? If so, which months;

Worst month(s)? Best month(s)?

Frequency of attacks? ☐ Daily ☐ Weekly ☐ Monthly ☐ Worse: ☐ Day ☐ Evening ☐ Night

FAMILY HISTORY:

<table>
<thead>
<tr>
<th></th>
<th>FATHER</th>
<th>MOTHER</th>
<th>BROTHER</th>
<th>SISTER</th>
<th>SON</th>
<th>DAUGHTER</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nasal Allergies (Hay Fever)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asthma</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Sinusitis</td>
<td></td>
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<td></td>
<td></td>
<td></td>
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<tr>
<td>Hives</td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

List all known allergies to drugs and food: (if none, please write none).

<table>
<thead>
<tr>
<th>Name of Drug</th>
<th>Describe Reaction</th>
</tr>
</thead>
<tbody>
<tr>
<td>A.</td>
<td></td>
</tr>
<tr>
<td>B.</td>
<td></td>
</tr>
<tr>
<td>C.</td>
<td></td>
</tr>
<tr>
<td>D.</td>
<td></td>
</tr>
</tbody>
</table>

Medicines: Include birth control pills, vitamins, and aspirin products if used often. Give the strength of prescription drugs you presently take.

<table>
<thead>
<tr>
<th>Medicines</th>
<th>A.</th>
<th>D.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>B.</td>
<td>E.</td>
</tr>
<tr>
<td></td>
<td>C.</td>
<td>F.</td>
</tr>
</tbody>
</table>

Hospitalizations and operations:

<table>
<thead>
<tr>
<th>YEAR</th>
<th>Reason for Hospitalization</th>
</tr>
</thead>
<tbody>
<tr>
<td>A.</td>
<td></td>
</tr>
<tr>
<td>B.</td>
<td></td>
</tr>
<tr>
<td>C.</td>
<td></td>
</tr>
<tr>
<td>D.</td>
<td></td>
</tr>
<tr>
<td>E.</td>
<td></td>
</tr>
</tbody>
</table>
Have you had previous skin testing?  □ No  □ Yes, when?

If your symptoms include hay fever, nasal allergy, “sinus”, wheezing, cough, shortness of breath, or asthma, please read the following list. Carefully and indicate by placing an “X” in the appropriate boxes to the left of those items that cause or aggravate, relieve or have no apparent effect upon your allergy symptoms.  EVEN A SMALL CHANGE IS SIGNIFICANT. If you have never encountered the situation or item, please leave all three boxes blank. If your symptoms DO NOT include any of those mentioned above, please leave this section blank.

<table>
<thead>
<tr>
<th>Causes or Aggravates</th>
<th>Relieves</th>
<th>No Effect</th>
<th>Items</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lawn mowing, grass contact</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Weed contact, specify:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Blossoming trees, specify:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>High winds, riding in auto with open windows</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Strong odors, sprays, perfumes, paints</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Musty, moldy, or mildewed places or articles</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Going indoors</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Going outdoors</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sweeping, dusting, vacuuming in the house, dusty books, etc.</td>
<td></td>
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<tr>
<td>Any animals, specify:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aspirin or aspirin-containing medications</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Emotional upset</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Exertion or strenuous exercise, specify:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Respiratory infections, virus infection, “flu”</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Air conditioning, swamp coolers, etc., please circle</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Antihistamines or nasal decongestants (Contac, Dristan, Allerest, Dimetapp, Ornade, Drixoral nasal spray, etc.), specify:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medications for wheezing (Tedral, Marax Bronkaid, theophylline, aminophylline, terbutaline, Alupent, etc.), circle and specify if other:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Corticosteroids (cortisone type drugs), specify:</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Other drugs which aggravate or relieve symptoms, specify:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Very cold weather, changes in temperature or barometric pressure, please circle</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Any trips out of this area, specify place and time of the year:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alcoholic beverages, specify:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Menstrual periods and/or pregnancy, please circle</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tobacco smoke and other smokes, smog, fumes and haze, please circle</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anything else you have noticed that changes your symptoms, specify:</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Smoking in house</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Patient smokes</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>□ packs □ years</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Alcohol</td>
<td>□ daily □ social</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Nonprescription drugs</td>
<td>□</td>
<td>□</td>
<td></td>
</tr>
<tr>
<td>ENVIRONMENT: Please check:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>House</td>
<td>□ own</td>
<td>□ rent</td>
<td>□ years</td>
</tr>
<tr>
<td>Apartment</td>
<td>□ own</td>
<td>□ rent</td>
<td>□ years</td>
</tr>
<tr>
<td>Animals</td>
<td>□ indoor</td>
<td>□ outdoor</td>
<td>□ bedroom</td>
</tr>
<tr>
<td>Pillow</td>
<td>□ leather</td>
<td>□ foam</td>
<td>□ synthetic</td>
</tr>
<tr>
<td>Carpet</td>
<td>□ wall to wall</td>
<td>□ wood floor</td>
<td></td>
</tr>
<tr>
<td>Heating</td>
<td>□ wall heater</td>
<td>□ central heat</td>
<td>□ gravity</td>
</tr>
<tr>
<td>Mattress</td>
<td>□ standard</td>
<td>□ waterbed</td>
<td></td>
</tr>
<tr>
<td>Box Spring</td>
<td>□ standard</td>
<td>□ none</td>
<td></td>
</tr>
<tr>
<td>Mold</td>
<td>□ indoor plants</td>
<td>□ bathroom</td>
<td>□ kitchen</td>
</tr>
</tbody>
</table>