ALLERGY QUESTIONAIRE

Patient Name: ______________________________ **Date:** ______________________________

Address: ______________________________ **Date of Birth:** ______________________________

City, State, Zip: ______________________________ **Home#:**______________________________

Gender (circle one): **MALE FEMALE** **Work#:**______________________________

Primary Care Physician: ______________________ **Referring Physician:** ______________________

Although your history and symptoms are very important in our analysis of your condition, it is also important for us that you understand:

- *We do not treat symptoms or diseases.*
- *Allergy is not a disease, rather a condition.*
- *A symptom is an attempt by your body to tell you something.*
- *We will attempt to find the underlying cause.*
- *We do not use drugs in this program.*
- *There is no single "healthy" diet that will work for everyone.*
- *Just because food is considered "healthy", does not mean it is "healthy" for you.*
- *Your diet consists of everything you* ***eat, drink, rub on your skin****, or* ***inhale****.*
- *Our procedures are safe and painless.*

Briefly describe the reason for your visit and what you hope to accomplish:

____

____

AGE WHEN SYMPTOMS WERE FIRST OBSERVED

☐ Infant (Age 0 -2) ☐ Child (Age 3 – 5)

☐ Child (Age 6 – 12) ☐ Adolescent (Age 13 – 18)

☐ Adult (Age 19 – 25) ☐ Adult (Age 26 – 40)

☐ Adult (Age 40)

DID YOU SUFFER FROM ANY TYPE OF PHYSICAL, CHEMICAL OR EMOTIONAL TRAUMA JUST BEFORE YOUR SYMPTOMS WERE FIRST OBSERVED?

____

HAVE YOUR SYMPTOMS EVER GONE AWAY FOR ANY PERIOD OF TIME?

____

PREVIOUS DIAGNOSIS OF ALLERGY

☐ Yes, and allergy shots helped
☐ Yes, but allergy shots did not help
☐ Yes, and medication helped
☐ Yes, but medication did not help
☐ None

FAMILY MEMBERS WITH ALLERGIC SYMPTOMS

☐ Mother
☐ Father
☐ Brother/Sister
☐ Grandparents
☐ Son/Daughter
☐ Spouse
☐ None

FREQUENCY & SEVERITY OF ALLERGY SYMPTOMS

☐ Constant, Chronic with Little Change
☐ Present Most of the Time
☐ Present Part of the Time
☐ Present Rarely
☐ No Interference with Normal Life
☐ Slight Interference with Normal Life
☐ Considerable Interference with Normal Life
☐ Prevents Some Normal Activities

SYMPTOMS ARE WORSE

☐ Outdoors, and better indoors
☐ At nighttime
☐ In the bedroom or when in bed
☐ During windy weather
☐ During wet or damp weather
☐ When the weather changes
☐ During known pollen seasons
☐ In certain rooms or buildings
☐ When exposed to tobacco smoke
☐ With yard work, cut grass, leaves, hay or barns
☐ When sweeping or dusting the house
☐ In areas with mold or mildew
☐ In air conditioning
☐ In fields or in the country
☐ Tobacco smoke bothers me more than anything else

SYMPTOMS ARE BETTER

☐ After shower or bath
☐ In air conditioning
☐ Indoors
☐ During or after physical activity
☐ After taking antihistamines
☐ With allergy shots

What makes you feel better?

____

ANIMALS, INSECTS AND BIRDS THAT CAUSE SYMPTOMS ON EXPOSURE

☐ Dogs
☐ Cats
☐ Horses or Cattle
☐ Rodents (mice, guinea pigs, etc.)
☐ Rabbits
☐ Birds or Feathers
☐ Bees
☐ other__________________
☐ None

FOOD RELATED SYMPTOMS

☐ Symptoms flare 5 – 60 minutes after meals
☐ Some foods are craved or addictive
☐The smell or odor of some foods increases symptoms
☐ Some foods cause nasal symptoms
☐ Some foods cause swelling of mouth or tongue
☐ Some foods cause rashes or hives
☐ Some foods cause upset stomach or vomiting
☐ Some foods cause diarrhea
☐ Symptoms occur with restaurant salad bars or Asian foods
☐ Some foods cause headaches
☐ Symptoms occur with any regularly eaten food
☐ Some foods cause asthma
☐ Preservatives, additives or food coloring increase symptoms
☐ No problem with foods

FOODS THAT CAUSE SYMPTOMS FROM ONE HOUR TO THREE DAYS AFTER EXPOSURE.

☐ Eggs
☐ Milk
☐ Beef
☐ Corn
☐ Wheat
☐ Soybean
☐ Peanut
☐ Pork
☐ Fish
☐ Shellfish
☐ Orange or other citrus
☐ Potato
☐ Tomato
☐ Yeast
☐ Chocolate
☐ Coffee or Tea
☐ Other:
____

CHEMICALS THAT CAUSE SYMPTOMS

☐ Insecticides & Pesticides
☐ Paints & Household Cleaners
☐ Perfumes & Cosmetics
☐ Gasoline or Automobiles Exhaust
☐ Stove or Furnace Emissions
☐ The Smell of New Fabrics or Fabric Store
☐ Chemicals in the workplace
☐ Laundry Detergent
☐ Newsprint
☐ Other: ________________

☐ None

WHEN ARE YOUR SYMPTOMS WORSE: ☐ Year Round?

☐ January	☐ February	☐ March
☐ April	☐ May	☐ June
☐ July	☐ August	☐ September
☐ October	☐ November	☐ December

MEDICATIONS:

Do you take any of the following medications on a regular basis?

☐ Antihistamines
(Benadryl, Actifed, Chlortrimeton, Tylenol Sinus, Tylenol Sleep, Dimetapp, Drixoral, Trimalin, Atarax, Claritin, Allegra, Zyrtec, etc.)

☐ Bronchodilators
(Albuterol, Ventolin, Proventil, Serevent, or OTS's such as Primatine Mist, etc.)

☐ Steroid Inhalers
(Asmacort, Flovent, Pulmicort, Beclovent, Aerobid, Advair, etc.)

☐ Nasal Steroids
(Beconase, Flonase, Nasacort, Rhinocort, etc.)

☐Medications that affect the immune system
(Prednisone, Imuran, Methotrexate, Cellcept, Cytoxan, Cyclosporine, Tacrolimus, etc.)

☐ Chemotherapy
Please list any medications that you are currently taking: ____

____

SMOKING:
Do you presently smoke? ☐Yes ☐No ; If yes, average number of cigarettes per day: ________________

If yes, at what age did you start? _________

Does anyone smoke in your home? ☐Yes ☐No

PREVIOUS ALLERGY EVALUTION:

Have you ever seen an allergist? ☐ Yes ☐ No

Have you had allergy skin testing? ☐ Yes ☐ No

Did you have any positive reactions? ☐ Yes ☐ No If yes, please list positive allergens (include any medications):

Have you ever received allergy injections? ☐ Yes ☐ No

WORK ENVIRONMENT:

What is your occupation? ______________________________

Are you exposed to chemicals or strong odors at work? ☐ Yes ☐No: If yes, briefly explain:

____

____

Are your symptoms worse while at work? ☐ Yes ☐ No If yes, briefly explain:

____

ANY ADDITIONAL INFORMATION YOU WOULD LIKE US TO KNOW?

____

____

____

ANYTHING YOU WOULD LIKE TO ASK? ______________________________

____