

# The Family HealthCare Allergy & Asthma Specialists

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## ALLERGY QUESTIONNAIRE

Please complete as carefully as possible. All information is confidential. Your response will help us determine what is causing your symptoms.

Patient Name \_\_\_\_\_ Referred By \_\_\_\_\_  
 Street Address \_\_\_\_\_ Pediatrician/Family Practitioner \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ Home Phone ( ) \_\_\_\_\_  
 Occupation \_\_\_\_\_  
 Place of Employment \_\_\_\_\_  
 Work Phone ( ) \_\_\_\_\_  
 Cell Phone ( ) \_\_\_\_\_  
 Email \_\_\_\_\_  
 Patient Birthdate \_\_\_\_\_ Age \_\_\_\_\_  
 Male  Female   
 Married  Single  Other

**CHILDREN:**  
 Father's Name \_\_\_\_\_ Occupation \_\_\_\_\_  
 Mother's Name \_\_\_\_\_ Occupation \_\_\_\_\_

**ADULTS:**  
 Spouse's Name \_\_\_\_\_ Occupation \_\_\_\_\_  
 Employer \_\_\_\_\_ Business Phone \_\_\_\_\_

The main problems for coming here are: \_\_\_\_\_

	Yes	No
Itchy or watery eyes . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
Sneezing . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
Snoring or breathing through the mouth . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
Drainage down the throat . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
Frequent yellow or green nasal drainage . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
Coughing . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
Wheezing or shortness of breath . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
Bee sting reactions . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
Rashes . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
Hives . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
Swelling . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
Frequent infections . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
Headaches . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
Vomiting . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
Abdominal Pain . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
Diarrhea . . . . .	<input type="checkbox"/>	<input type="checkbox"/>

**SYMPTOMS ARE MADE WORSE BY**

<input type="checkbox"/> Colds	<input type="checkbox"/> Foods
<input type="checkbox"/> Cigarette Smoke	<input type="checkbox"/> Cats
<input type="checkbox"/> Mowing Grass	<input type="checkbox"/> Dogs
<input type="checkbox"/> Raking Leaves	<input type="checkbox"/> Heat
<input type="checkbox"/> Perfumes or Scents	<input type="checkbox"/> Cold
<input type="checkbox"/> Dusting/Cleaning	<input type="checkbox"/> Other _____

**THESE SYMPTOMS OCCUR**

Spring     Summer     Fall     Winter

Days or weeks at a time     All the time

At home    Room \_\_\_\_\_

Worse outdoors     At work     At school

All day     Worse at night or morning

Transfer of allergy care from Dr. \_\_\_\_\_  
 Continuation of allergy shots started \_\_\_\_\_ years ago  
 Diagnosis of asthma was made \_\_\_\_\_ years ago  
 Number of past hospitalizations for asthma \_\_\_\_\_  
 Days of school/work missed in past year \_\_\_\_\_  
 Possible reaction to (food or drug) \_\_\_\_\_  
 Number of ear infections in the past year \_\_\_\_\_  
 Number of sinus infections in the past year \_\_\_\_\_  
 Number of pneumonias during lifetime \_\_\_\_\_

Past Hospitalizations: \_\_\_\_\_

**CHILDREN ONLY**

	Yes	No
Full Term Pregnancy . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
Complicated Pregnancy . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
C-section Delivery . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
Birth Weight _____ lbs. _____ oz.		
Initial Feeding		
Breast _____ to age _____		
Bottle _____ to age _____		
Feedings Tolerated Well . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
Whole Milk . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
Began at Age _____		
List Any Problems _____		
_____		
_____		
Yes	No	
Immunizations up to date . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
Parents of the Patient are:		
<input type="checkbox"/> Alive <input type="checkbox"/> One is deceased <input type="checkbox"/> Both are deceased		
Primary residence is:		
<input type="checkbox"/> One home <input type="checkbox"/> Split between homes		

**FAMILY HISTORY**

	ALLERGIES	ASTHMA	FREQUENT COUGHING	FREQUENT INFECTIONS
Father . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mother . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Brother(s) . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sister(s) . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Grandfather(s) . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Grandmother(s) . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Uncle(s) . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Aunt(s) . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cousin(s) . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Other chronic conditions such as cystic fibrosis, emphysema, recurrent hives or swelling, lupus, rheumatoid arthritis, etc.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**PREVIOUS DISEASES**

	Yes	No
Measles (Rubeola) . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
German Measles (Rubella) . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
Mumps . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
Chicken Pox . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
Whooping Cough . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
Pneumonia . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
Bronchitis . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
Sinus Infection . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
Jaundice . . . . .	<input type="checkbox"/>	<input type="checkbox"/>

**LABORATORY TESTS**

	Where Done	Date	Normal	Abnormal
X-ray Chest Sinus				
Sweat Test				
TB Skin Test				
Allergy Skin Test				

**FOOD REACTIONS**

Food	Symptoms

**DRUG REACTIONS**

Drug	Symptoms

**CURRENT ENVIRONMENT**

	Yes	No	
Dogs .....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cats .....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Birds .....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other Pets .....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Feather Pillow .....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Down Comforter .....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Carpets/Rugs .....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Air Cleaner .....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cigarette Smoker .....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Forced Air Heat .....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Air Conditioning .....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Houseplants .....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Damp Basements .....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Stuffed Toys .....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Improved on Trips .....	<input type="checkbox"/>	<input type="checkbox"/>	_____

**CURRENT MEDICATIONS**

ALL CURRENT MEDICATIONS	NUMBER OF MG, TABS, CAPS OR INHALED PUFFS	
_____	_____	_____ times per day
_____	_____	_____ times per day
_____	_____	_____ times per day
_____	_____	_____ times per day
_____	_____	_____ times per day
_____	_____	_____ times per day
_____	_____	_____ times per day
_____	_____	_____ times per day

**REVIEW OF SYSTEMS**

	Yes	No	If yes, please explain
Fever .....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Weight loss .....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Skin problems other than eczema .....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Joint swelling or pain .....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Blood count problems (anemia, etc.) .....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eye problems (explain) .....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Throat infections .....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart problems .....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Joint swelling or pain .....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Stomach upset			
Heartburn/Indigestion .....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Regurgitation after meals, lying down or bending forward .....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Frequent use antacids .....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cough worse after meals or lying down .....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Urinary or bladder problems .....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Nerve problems .....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Psychiatric problems .....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hormone problems (hot flashes, etc.) .....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer .....	<input type="checkbox"/>	<input type="checkbox"/>	_____

Additional Comments \_\_\_\_\_

\_\_\_\_\_