**ALLERGY QUESTIONNAIRE**
*The Allergy & Asthma Group*
*Linden David Ho, MD & Michael Y. Viksman, MD*

*All questions contained in this questionnaire are strictly confidential and will become part of your medical record.*

<table>
<thead>
<tr>
<th>Name (Last, First, M.I.):</th>
<th>☐ M ☐ F</th>
<th>DOB:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary physician’s name</td>
<td>If patient is a child, this form is being completed by</td>
<td></td>
</tr>
<tr>
<td>Who referred you to this practice?</td>
<td>☐ primary doctor ☐ friend/family ☐ ins co ☐ web</td>
<td></td>
</tr>
<tr>
<td>Your occupation:</td>
<td></td>
<td></td>
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<tr>
<td>What is the main reason for today’s visit?</td>
<td>(provide details)</td>
<td></td>
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</tbody>
</table>

**Upper Respiratory Problems** (Nose, sinus, ears, eyes)

*Check box if not applicable* ☐

- ☐ nasal congestion
- ☐ runny nose
- ☐ post nasal drip
- ☐ itchy nose
- ☐ red or itchy eyes
- ☐ sinus pressure or pain
- ☐ poor sense of smell
- ☐ frequent ear infections
- ☐ frequent sinus infections
- ☐ frequent colds
- ☐ hoarse voice
- ☐ other

**Lower Respiratory Tract Problems** (Chest, lungs)

*Check box if not applicable* ☐

- ☐ frequent or constant cough
- ☐ wheezing
- ☐ chest tightness
- ☐ shortness of breath
- ☐ asthma
- ☐ frequent croup
- ☐ pneumonias
- ☐ frequent bronchitis
- ☐ other:

Are the above symptoms seasonal? Jan Feb Mar April May June July Aug Sept Oct Nov Dec ☐ All Year ☐ No Pattern

Are the symptoms triggered by any of these?

☐ pollen ☐ animals ☐ dust ☐ mold ☐ smoke or scents ☐ weather changes ☐ foods

**Skin Problems**

*Check box if not applicable* ☐

- ☐ eczema
- ☐ itching skin rash
- ☐ dry skin
- ☐ itchiness in general
- ☐ hives, welts
- ☐ swelling of parts of the body
- ☐ blistery rashes
- ☐ pimply rashes
- ☐ acne
- ☐ frequent boils
- ☐ other:
Food Allergies

Check box if not applicable □

<table>
<thead>
<tr>
<th>Food</th>
<th>Reaction noted</th>
<th>When did the reaction occur? (age or date)</th>
<th>Is the food completely avoided?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>□ yes □ no</td>
</tr>
<tr>
<td></td>
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<td>□ yes □ no</td>
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<td>□ yes □ no</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>□ yes □ no</td>
</tr>
</tbody>
</table>

What medications are you taking? (list both prescription and non-prescription)

Name of Drug | Which strength? | Frequency
-----|----------------|-----
      |                |     
      |                |     
      |                |     

Your Medical History:

- □ asthma
- □ hay fever
- □ eczema
- □ hives
- □ food allergies
- □ high blood pressure
- □ atrial fibrillation
- □ MI/cardiac stent
- □ pacemaker
- □ arthritis
- □ cholesterol high
- □ diabetes
- □ thyroid low
- □ emphysema/COPD
- □ GERD/reflux
- □ Crohn’s/ulcerative colitis
- □ celiac disease
- □ cancer (type):
- □ chemotherapy
- □ attention deficit
- □ depressive disorder
- □ anxiety disorder
- □ other not listed (inc surgeries):

Smoking History  □ I currently smoke  □ I never smoked (skip other questions)  □ N/A because patient is child

Have you smoked at least 100 cigarettes in your entire life? □ yes □ no

If currently smoking, are you a □ everyday smoker □ smoke some days only □ former smoker, year quit _____

□ cigarettes  #pks./day _____ □ pipe - #/day_____ □ cigars - #/day_____ □ smokeless tobacco - #/day_____

□ # of years total _____

Family history of allergies? (hay fever, asthma, eczema, food allergies, drugs)

□ father  □ mother  □ brothers or sisters  □ aunts or uncles  □ grandparents
### Review of Systems

**Circle any symptoms that apply to you:**

**Not applicable**

<table>
<thead>
<tr>
<th>Category</th>
<th>Symptoms</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>General:</strong></td>
<td>insomnia, tiredness</td>
</tr>
<tr>
<td><strong>Throat:</strong></td>
<td>sore throat, hoarseness, postnasal drip</td>
</tr>
<tr>
<td><strong>Eyes:</strong></td>
<td>itchy eyes, watery eyes, swollen eyes</td>
</tr>
<tr>
<td><strong>Lungs:</strong></td>
<td>cough, chest tightness, wheezing, shortness of breath</td>
</tr>
<tr>
<td><strong>Neuro:</strong></td>
<td>anxiety disorder, panic attacks, depression</td>
</tr>
<tr>
<td><strong>Joints:</strong></td>
<td>swollen joints</td>
</tr>
<tr>
<td><strong>Head:</strong></td>
<td>severe or frequent headaches, dizziness</td>
</tr>
<tr>
<td><strong>Chest/heart:</strong></td>
<td>chest pain, palpitations</td>
</tr>
<tr>
<td><strong>Skin:</strong></td>
<td>hives, easy bruising</td>
</tr>
<tr>
<td><strong>Ears:</strong></td>
<td>ear congestion, decreased hearing, frequent ear infections</td>
</tr>
<tr>
<td><strong>GI:</strong></td>
<td>difficulty swallowing, acid reflux, stomach pain, diarrhea, nausea, vomiting</td>
</tr>
<tr>
<td><strong>Nose:</strong></td>
<td>itchy nose, stuffiness, sinus pressure</td>
</tr>
<tr>
<td><strong>Other not listed:</strong></td>
<td></td>
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</tbody>
</table>

### Allergies to Medications

<table>
<thead>
<tr>
<th>Name of drug…</th>
<th>Reaction you had</th>
</tr>
</thead>
</table>

### Environmental Survey

- **What kind of trees are on your property, if known?**
- **Heating system:**
  - □ forced air
  - □ other
- **Mold problems?**
  - □ yes
  - □ no
- **Allergy encasing on mattress?**
  - □ yes
  - □ no
- **Feather pillow or down comforter?**
  - □ yes
  - □ no
- **Pets:**
  - □ no
  - □ yes (how many) dogs _____ cats _____ other _____
- **Cigarette smokers inside the house?**
  - □ yes
  - □ no
- **Any school or workplace exposures you are concerned about?**

*For office use:*