ALLERGY QUESTIONNAIRE
Please bring to your first office visit

Date: _____
Name: _____
DOB/AGE: _____
Primary Physician: _____
What symptoms do you have that need an allergy evaluation?: _____

Please list all medications you take regularly (including birth control, aspirin, and any drug purchased over-the-counter):

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____

Please list any adverse drug reactions:

Drug	Reaction:	At what age?
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____

Past Medical History

Medical Conditions (including psychiatric)
1. _____
2. _____
3. _____
4. _____
5. _____

Hospitalizations, ER visits and surgeries
1. _____
2. _____
3. _____
4. _____
5. _____

Past Allergy History

Name of allergist: _____ when seen: _____ allergy shots? ___Yes ___ No
Allergy test results: _____

Environmental History for our allergy and asthma patients only:
(circle or fill in all that apply)

Housing: House/Apt. Age ___, Length of stay _____, damp basement: Y/N, pets: Y/N, kind _____
cockroaches: Y/N, smokers: Y/N
Heating: Forced air, baseboard, radiator, other _____
Air conditioning: central/window unit Humidifier: Y/N Dehumidifier: Y/N
Bedroom: carpeting/hardwood/area rugs/other_____

General Health History (circle all that apply)

Ears/Nose/Throat	***Heart***	***Lungs***	***Skin***
Runny nose	Palpitations/arrhythmia	Wheezing	Eczema
Sinus infections		Frequent bronchitis	Chronic rashes
Itchy or watery eyes	**Gastrointestinal**	Frequent cough	Itching
Dry eyes	Reflux	Shortness of breath	Swelling: Where _____
Headaches	Recurrent heartburn		
Swollen glands			
Congestion			
Post nasal drainage			

Triggers for your symptoms:
Exercise Cold air Night time Weather changes Laughing
Strong Odors Respiratory infections Other _____

Other
Alcohol use: Yes/No Frequency: _____
IV or other drug use: _____
Smoking: Yes/No Age started _____ packs/day _____

General Health
Regular exercise? Yes/No Type: _____
Unexplained weight loss
Fever, chills, sweats

Family History (indicate relationship to problems listed below. Examples: mother and sister)

Asthma: _____
Nasal allergies: _____
Sinus problems: _____
Eczema/rashes: _____
Urticaria/Hives: _____

What other diseases run in your family?_____
_____

Social History

Who lives at home with you? _____
Are there other households you stay at frequently? _____
(Example: weekends at grandmother's who smokes and owns a cat)

What kind of work do you do? _____ Are there any environmental exposures you are concerned about (ex: solvents at work). _____

Education completed (check one): _____ elementary ____ high school _____ college _____ other
Do you require assistance reading and filling out forms? _____

What is your primary language? _____ Do you use an interpreter? _____