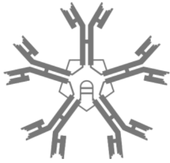

Exton Allergy & Asthma Associates

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ALLERGY QUESTIONNAIRE

Name: ________________________ **Date of birth:** ____________ **Age:** _______ **Gender:** ______

You were referred by: ________________ **Primary MD:** ________________ **Date:** ____________

Reason(s) for visit and when did it begin (year):

1. ______________________________ 2. ______________________________

3. ______________________________ 4. ______________________________

Have you ever been diagnosed with asthma? ☐ No ☐ Yes When? ____________

Do you **currently** have symptoms**?** ☐ No ☐ Yes

Cough ☐ No ☐ Yes
☐ Dry ☐ Productive

Wheezing ☐ No ☐ Yes
☐ While breathing in ☐ Breathing out

Shortness of breath ☐ No ☐ Yes
☐ At rest ☐ With exertion

Chest discomfort ☐ No ☐ Yes
☐ Chest tightness ☐ Chest pain

How often do you experience shortness of breath, wheezing or chest tightness?
☐ Every day ☐ Every other day ☐ Twice a week ☐ Once a week ☐ Twice a month ☐ Once a month

Does shortness of breath or chest tightness **awaken you from sleep**? ☐ No ☐ Yes If yes how often?
☐ Every day ☐ Every other day ☐ Twice a week ☐ Once a week ☐ Twice a month ☐ Once a month

How many puffs of rescue inhaler (albuterol) do you use **per week?** ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ More

Does asthma slow you down or **limit your exercise?** ☐ Never ☐ Rarely ☐ Sometimes ☐ Frequently ☐ Always

What causes your asthma to **worsen?** ____

Does asthma affect the **quality of your life?** ☐ Never ☐ Rarely ☐ Sometimes ☐ Frequently ☐ Always

Have you been **hospitalized for asthma?** ☐ No ☐ Yes **How many times?** _____ **Intensive care unit?** ☐ No ☐ Yes

Have you been to an **emergency room** in the **last year for asthma?** ☐ No ☐ Yes How many times? ______

Have you taken **prednisone** or other steroids **for asthma?** ☐ No ☐ Yes How often in the **past 12 months?** _______

Do you have a **peak flow meter?** ☐ No ☐ Yes **Best** peak flow**:** _____ Normal range**:** ________ Past two weeks? ________

* * * * *

Do you have any nasal symptoms or sinus problems? ☐ No ☐ Yes When did they begin? ________________

Runny nose ☐ No ☐ Yes
☐ Watery ☐ Thick ☐ Clear ☐ Colored

Itchy nose ☐ No ☐ Yes

Blocked nose or congestion ☐ No ☐ Yes

Frequent or repetitive sneezing ☐ No ☐ Yes

Drainage into the throat or throat clearing ☐ No ☐ Yes

Sinus pain/pressure ☐ No ☐ Yes
☐ Cheeks ☐ Forehead ☐ Between eyes

Nasal or sinus polyps ☐ No ☐ Yes

Loss of sense of smell or taste ☐ No ☐ Yes

Do you have any eye symptoms? ☐ No ☐ Yes

Itchy eyes ☐ No ☐ Yes

Red eyes ☐ No ☐ Yes

Watery eyes or tearing ☐ No ☐ Yes

Irritated eyes ☐ No ☐ Yes

Where are symptoms **worse?** ☐ Outdoors ☐ Indoors: ☐ Home ☐ Work ☐ Other (specify) ____________________

Are symptoms **year-round?** ☐ No ☐ Yes Symptoms worsen **seasonally** in: ☐ Spring ☐ Summer ☐ Fall ☐ Winter

In which **months** do symptoms worsen? ☐ Jan ☐ Feb ☐ Mar ☐ Apr ☐ May ☐ Jun ☐ Jul ☐ Aug ☐ Sep ☐ Oct ☐ Nov ☐ Dec

What time of the day or night are symptoms **most severe**? ☐ Morning ☐ Afternoon ☐ Evening ☐ Night

Do any of the following trigger or worsen your symptoms?

Trigger	No	Yes	**Trigger**	No	Yes	Trigger	No	Yes
Cutting grass/mowing lawn	☐	☐	Exercise	☐	☐	Infections (colds)	☐	☐
Dusting or vacuuming	☐	☐	Emotions (tension, frustration)	☐	☐	Smoking, smoke or fumes	☐	☐
Damp or musty areas	☐	☐	Cold air	☐	☐	Strong odors or perfumes	☐	☐
Raking leaves/decaying vegetation	☐	☐	Dry weather	☐	☐	Hot (temperature) food	☐	☐
Barns/hay	☐	☐	High humidity	☐	☐	Hot (spicy) food	☐	☐
House plants	☐	☐	Rain or change in weather	☐	☐	Food (specify)	☐	☐
Pets (specify)	☐	☐	Wind or draft	☐	☐	Drugs (specify)	☐	☐

Other triggers: ____________________

Have you ever been **tested for allergies?** ☐ No ☐ Yes How? ☐ Skin test ☐ Blood test When? ____________

To what was allergy detected? ☐ Dust mite ☐ Molds ☐ Cockroach ☐ Cat ☐ Dog ☐ Feather ☐ Trees ☐ Grass ☐ Weeds

Have you ever been treated with **allergy shots?** ☐ No ☐ Yes When and for how long? ____________________

* * * * *

Do you have any skin symptoms? ☐ No ☐ Yes ☐ Itching ☐ Flushing ☐ Dryness ☐ Rash

Do you have **eczema** or **atopic dermatitis?** ☐ No ☐ Yes When did it begin? ____________________

What causes it to **worsen?** ____________________

* * * * *

Do you have hives? ☐ No ☐ Yes When did they begin? ____________________

How often? ☐ Daily ☐ A few times per week ☐ Weekly ☐ A few times per month ☐ Monthly ☐ Occasionally

Do you have recurrent **swelling?** ☐ No ☐ Yes **Which body part?** ☐ Eyelids ☐ Lips ☐ Face ☐ Limbs ☐ Trunk

Do any of the following symptoms occur in **association with hives or swelling?** ☐ Shortness of breath ☐ Wheezing ☐ Lightheadedness ☐ Throat tightness ☐ Difficulty swallowing ☐ Abdominal cramps ☐ Vomiting ☐ Diarrhea

Do your hives result in: ☐ Burning ☐ Pain ☐ Bruising ☐ Blood spots

Are hives **aggravated or triggered** by: ☐ Vibration ☐ Pressure ☐ Exercise ☐ Heat ☐ Cold ☐ Food ☐ Drugs ☐ Sunlight

Do you **suspect** any causes? ____________________

Do hives interfere with your ability to **sleep?** ☐ No ☐ Yes

Do hives affect the **quality of your life?** ☐ Never ☐ Rarely ☐ Sometimes ☐ Frequently ☐ Always

Have you taken **prednisone** or other steroids **for hives?** ☐ No ☐ Yes How often in the past 12 months? _______

* * * * *

Do you have headaches? ☐ No ☐ Yes Which side? ☐ Right ☐ Left ☐ Both

How often? ☐ Daily ☐ 2-3 times per week ☐ Once a week ☐ Twice a month ☐ Once a month ☐ Occasionally

How **severe** are your headaches? ☐ Mild ☐ Moderate ☐ Severe ☐ Very severe

Are your headaches **throbbing or pounding?** ☐ No ☐ Yes Are they worse with menstrual periods? ☐ No ☐ Yes

Are the headaches **associated** with: ☐ Nausea ☐ Vomiting ☐ Dislike for light ☐ Dislike for sound ☐ Irritability

Does headache **awaken you from sleep?** ☐ No ☐ Yes Does sleep improve your headache? ☐ No ☐ Yes

* * * * *

Do you have **frequent infection?** ☐ No ☐ Yes **What kind?** ☐ Common colds ☐ Sinus ☐ Ear ☐ Chest ☐ Skin

How many infections do you have **per year?** ______ How many courses of **antibiotics** do you take per year? ______

Have you had a **chest X-ray?** ☐ No ☐ Yes **Chest CT?** ☐ No ☐ Yes **Sinus CT?** ☐ No ☐ Yes

Have you had **nasal or sinus surgery?** ☐ No ☐ Yes **When?** _________ **Who performed it?** ________________

List all medicines that you currently take:

Name	Dose	How often	Name	Dose	How often

Do you have any drug allergies? ☐ No ☐ Yes

Drug	Symptoms of adverse reaction	Date	Has the drug been taken since

Do you have any food allergies? ☐ No ☐ Yes

Food	Symptoms of adverse reaction	Date	Treatment	Symptoms on re-exposure

Do you have any sensitivity to insect stings? ☐ No ☐ Yes

Symptoms of adverse reaction	# of stings	Date	Treatment

Have you ever had any of the following illnesses?

	No	Yes		No	Yes		No	Yes
Hypertension	☐	☐	Recurrent/chronic sinusitis	☐	☐	Reflux or GERD	☐	☐
Heart disease	☐	☐	Tuberculosis (Tb)	☐	☐	Cancer	☐	☐
Emphysema or COPD	☐	☐	Stomach/intestinal disease	☐	☐	What Kind?		
Recurrent/chronic bronchitis	☐	☐	Liver disease	☐	☐	Diabetes	☐	☐
Pneumonia	☐	☐	Kidney disease	☐	☐	Thyroid disease	☐	☐

Please list any other health concern: ______________________________

Have you had any surgeries? Please list.

Surgery	Year	Surgery	Year

Immunizations

Childhood vaccinations: Up to date? ☐ No ☐ Yes Vaccines not received: ______________________________

Influenza vaccine: ☐ No ☐ Yes Date: ____________ Pneumonia vaccine: ☐ No ☐ Yes Date: ____________

Have you ever taken medications to treat any of the following conditions?

Nasal/eye allergies or hay fever ☐ No ☐ Yes

Asthma or reactive airway disease ☐ No ☐ Yes

Eczema or atopic dermatitis ☐ No ☐ Yes

Hives or urticaria ☐ No ☐ Yes

What medicines have **improved** your symptoms?

Name	Dose	How often

What medicines have you tried **without improvement?**

Name	Dose	How often

Have you experienced any side effects from any of those medicines? ☐ No ☐ Yes

Medicine	Side-effect	Medicine	Side-effect

Social History and Environmental Survey

Do you currently smoke? ☐ No ☐ Yes Do you want to quit? ☐ No ☐ Yes Are you exposed to tobacco smoke? ☐ No ☐ Yes

Have you ever smoked? ☐ No ☐ Yes How many packs per day? _____ How many years? _____ When did you quit? _________

Do you drink alcoholic beverages? ☐ No ☐ Yes How much? __________________ How often? ___________________

Where do you live? ☐ House ☐ Town house ☐ Farm house ☐ Trailer ☐ Apartment ☐ Other __________________

Age of current dwelling: ____________ Number of years at present address: _______

Who lives at home with you? ____

Is there a basement? ☐ No ☐ Yes ☐ Finished ☐ Unfinished ☐ Dry ☐ Damp ☐ Musty smelling

Is there carpeting? ☐ No ☐ Yes ☐ Bed room ☐ Family room ☐ Dining room ☐ Living room

Are pillows and mattress encased in special covers? ☐ No ☐ Yes Are there house plants? ☐ No ☐ Yes

Is there any visible water damage or mold growth in your home? ☐ No ☐ Yes Where? _________________________________

Is there air conditioning? ☐ Central ☐ Wall/window unit

What is the heat source? ☐ Forced air ☐ Radiator ☐ Floor heating ☐ Wood burning stove ☐ Other ___________________

Are there pets in your home? ☐ No ☐ Yes What kind? ☐ Cat ☐ Dog ☐ Other ________________ ☐ Outdoors ☐ Indoors

Also in bedroom? ☐ No ☐ Yes Other contact with animals? ☐ No ☐ Yes What kind(s)? ___________________

Where? _________________ How often? _________________ Any symptoms upon exposure? ☐ No ☐ Yes

Occupational History

What is your occupation? __________________________________ Have you had any worksite exposure? ☐ No ☐ Yes

What type of exposures ____ When? __________________

Day care? ☐ No ☐ Yes Since what age? __________ With how many other children? _________

Family history	Father	Mother	Brother	Sister	Son	Daughter	Grandfather	Grandmother	Aunt	Uncle
Asthma	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Hay fever/nasal allergies	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Eczema/atopic dermatitis	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Hives	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Thyroid disease	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Cystic fibrosis	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Frequent infections	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Other:	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Review of systems

GENERAL: ☐ Fever ☐ Chills ☐ Night sweats ☐ Unintentional weight loss ☐ Excessive weight gain

EARS: ☐ Ear pain ☐ Ear pressure ☐ Ear discharge ☐ Hearing loss ☐ Ringing in ear ☐ Popping

EYES: ☐ Glaucoma ☐ Vision change ☐ Irritation ☐ Redness ☐ Watery eyes ☐ Dry eyes

NOSE: ☐ Dryness ☐ Irritation ☐ Bleeding ☐ Discharge ☐ Post nasal drainage

MOUTH: ☐ Ulcers ☐ Sore throat ☐ Itching ☐ Gum disease ☐ Bad breath ☐ Sour/bitter taste

THROAT: ☐ Enlarged tonsils ☐ Sore throat ☐ Itching ☐ Lump or swelling ☐ Throat clearing ☐ Hoarseness

HEART: ☐ Chest pain ☐ Abnormal heart beats ☐ Exercise intolerance ☐ Swelling in feet and ankles

LUNGS: ☐ Excessive mucus/phlegm ☐ Coughing up blood or bloody sputum ☐ Painful breathing

ABDOMEN: ☐ Belly pain ☐ Nausea ☐ Vomiting ☐ Diarrhea ☐ Heartburn ☐ Water brash

GENITOURINARY: ☐ Frequent urination ☐ Slow urine flow ☐ Difficulty passing urine ☐ Prostate enlargement

HORMONAL: ☐ Excessive thirst ☐ Cold intolerance ☐ Heat intolerance ☐ Excessive sweating ☐ Irregular periods

SKIN: ☐ Dry skin ☐ Nail problem ☐ Hair loss

MUSCULOSKELETAL: ☐ Joint pain ☐ Joint swelling ☐ Stiffness ☐ Muscle pain ☐ Weakness

NEUROLOGIC: ☐ Dizziness ☐ Loss of function ☐ Loss of sensation ☐ Fatigue

MENTAL HEALTH: ☐ Poor memory ☐ Confusion ☐ Depression ☐ Anxiety ☐ Insomnia

SLEEP: ☐ Poor quality ☐ Snoring ☐ Lack of refreshing sleep ☐ Daytime sleepiness ☐ Falling asleep involuntarily

Form filled out by: ________________________________ **Relationship to the patient:**______________________________