

ALLERGY ASSOCIATES & LAB., LTD.

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IF UNABLE TO KEEP APPOINTMENT, KINDLY GIVE 24 HOURS NOTICE

ALLERGY QUESTIONNAIRE	Patient's Name:	Account No.
	OCCUPATION	DATE:

Please try to answer these questions accurately as the information is of considerable importance to your allergist in the evaluation of your condition. If you have difficulty with any of the questions, check with the nurse who will see you after you have completed this form.

What is your main reason for coming to see an allergist?

When did this problem start? _____

How severe is the problem? _ mild _ moderate _ severe _ other: _____

Is the problem present most of the time? Yes No (circle one) If it is only present occasionally, how often does it occur?

Is it worse during certain months? Yes No (circle one) If yes, please list which months:

What relieves the problem? _____

What makes it more severe? _____

What other related symptoms are you having? _____

Where were you living when the problems started? _____

If you have moved since the symptoms began, list the cities or areas in which you have lived and indicate to the right of each area whether symptoms were unchanged, less severe, or more severe in that area.

AREAS	SEVERITY OF SYMPTOMS

What other symptoms do you have that you believe are due to allergies?

Have you been studied or treated by an allergist in the past or has any other physician done allergy skin tests or given injections for allergy. Yes No (circle one) Specify years and details:

Read the following list carefully and indicate by checking in the appropriate boxes to the left of each item, which items cause or aggravate, relieve or have no apparent effect upon your allergy symptoms. Even a small change is significant. Leave all boxes blank if you have never encountered the situation or item.

Cause or Aggravate	Relieve	No Change	ITEMS
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lawn mowing, grass contact
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Weed contact, specify: _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Blossoming trees, specify: _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High winds, riding in auto with open windows
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Raking leaves
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Musty, moldy or mildewed places or articles
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Going indoors
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Going outdoors
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sweeping, dusting, vacuuming in the house, dusty books, etc.
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Any animals, specify: _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Taking any medications (including aspirin, etc.) specify: _____
<hr/>			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Emotional upset
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Exertion or heavy exercise, specify: _____
<hr/>			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory infection, virus infection, flu
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Insect spray
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hair spray, cosmetics, talcums, aftershaves, perfumes, etc. specify: _____
<hr/>			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Air conditioning, swamp coolers, etc. specify: _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Antihistamines or nasal decongestants (Allegra, Claritin, Zyrtec, etc.) specify: _____
<hr/>			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Medications for wheezing (Albuterol, Maxair, Serevent, etc.) specify: _____
<hr/>			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Adrenalin or Epinephrine
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Steroids (Cortisone type drugs, i.e. nasal sprays and/or inhalers) specify: _____
<hr/>			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other drugs, specify: _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Very cold weather or changes in weather
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Trips to the mountains
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Trips to the desert
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Trips to the seashore
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Any other trips out the this area, specify place and time of year _____
<hr/>			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Menstrual periods and/or pregnancy, specify: _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tobacco smoke
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Anything else you have noticed, specify: _____

Have you ever had any of the following conditions? If so check the appropriate boxes & specify during which years (and if applicable, seasons) and in what area you were living at the time, if you have not already answered these above.

- Hay fever
 - Nasal allergy all year ("sinus")
 - Asthma (wheezing, shortness of breath) describe: _____
-
- Hives, urticaria, angioedema (facial swelling, etc.) Circle appropriate word or words.
 - Eczema
 - Skin rash due to allergy or contact, specify cause: _____
 - Poison oak, ivy or sumac rash, specify which ones: _____
 - Food Allergy, specify foods and what symptoms they cause. Specify and describe any other unusual reaction when you eat any particular food: _____
-

Drug allergy (specify the drugs and the symptoms which occur: None that I know of

Unusual reaction to insect bites or stings. (Specify the insects, describe the reactions and give the dates when they occurred):

PAST MEDICAL HISTORY: Have you had in the past or do you currently have any of the following? (Please check the appropriate box.)

- Diabetes ulcer of the stomach or duodenum pneumonia
- cataracts COPD, chronic bronchitis, or emphysema bronchitis
- osteoporosis/osteopenia high blood pressure heart attack
- glaucoma GERD or acid reflux or hiatal hernia Valley Fever
- Thyroid disease (high or low) Stroke tuberculosis
- bleeding from the gastrointestinal tract sleep apnea
- autoimmune disease (e.g., lupus, rheumatoid arthritis)
- Cancer Type: _____ How treated: chemotherapy radiation surgery
- Other _____

PAST SURGICAL HISTORY: Please list all surgical procedures that you have had and list the **approximate** dates. (Include tonsillectomy.)

Type of surgery	Approximate date of surgery
_____	_____
_____	_____
_____	_____
_____	_____

PRIOR DIAGNOSTIC TESTS: Have you ever had any of the following exams?

Test	Response	Approx. date of last test	Finding
Colonoscopy	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	<input type="checkbox"/> normal <input type="checkbox"/> abnormal
Mammogram	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	<input type="checkbox"/> normal <input type="checkbox"/> abnormal
Chest x-ray	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	<input type="checkbox"/> normal <input type="checkbox"/> abnormal
CT scan of sinuses	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	<input type="checkbox"/> normal <input type="checkbox"/> abnormal
Cardiac stress test	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	<input type="checkbox"/> normal <input type="checkbox"/> abnormal
Bone mineral density test	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	<input type="checkbox"/> normal <input type="checkbox"/> abnormal
Prostate biopsy or blood test	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	<input type="checkbox"/> normal <input type="checkbox"/> abnormal
Skin biopsy	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	<input type="checkbox"/> normal <input type="checkbox"/> abnormal

If any of the above were abnormal, please explain:

Do you / did you ever smoke? Yes No **If so, how much and what? _____**
For how many years? _____ **When did you quit? _____**

FAMILY HISTORY: In your family as listed, did anyone have any of the following numbered conditions? Indicate the number to the right of the appropriate blood relative: (e.g., patient's mother 1, 6, 11)

- | | | |
|------------------------------------|--------------------------------------|----------------------|
| Patient's mother | 1. Hay fever | 16. Leukemia |
| Patient's father | 2. Nasal allergy | 17. Lymphoma |
| Patient's brothers or sisters | 3. "Sinus" | 18. Other cancer |
| Patient's maternal aunts or uncles | 4. Asthma | 19. Immunodeficiency |
| Patient's maternal grandparents | 5. Hives | |
| Patient's paternal aunts or uncles | 6. Eczema | |
| Patient's paternal grandparents | 7. Food allergy | |
| Patient's children | 8. Drug allergy | |
| | 9. Insect allergy | |
| | 10. Emphysema or other lung diseases | |
| | 11. Diabetes | |
| | 12. Tuberculosis | |
| | 13. Lupus | |
| | 14. <u>Rheumatoid</u> arthritis | |
| | 15. Thyroid disease | |

REVIEW OF SYSTEMS: Please check if you have any of the following:

- GENERAL: None unexplained weight gain or loss unexplained fevers or shaking chills
 waking up with your bedsheets or nightclothes soaking wet with sweat
- SKIN/BREASTS: None Breast lumps Nipple discharge Hives Eczema
 Other rashes: _____
- EYES/EARS/NOSE/MOUTH/THROAT: None Headaches Lightheadedness Visual changes
 Nosebleeds dentures or partials hoarseness tightness in the throat or choking sensation
- CARDIOVASCULAR: None palpitations/racing or fluttering of heart heart murmur irregular heart rhythm
 swelling of the feet/ankles shortness of breath when lying flat
- RESPIRATORY: None shortness of breath wheezing
 Cough If yes, do you bring up mucous? No Yes If yes, what does it look like? clear whitish
 dark yellow/green/brown Other: _____ Do you cough up blood? Yes No
- GASTROINTESTINAL: None Nausea Vomiting abdominal cramping diarrhea blood in stool
 heartburn (burning in the stomach, chest, or throat) taste of vomit in the mouth without vomiting
 food sticking when swallowing impaired liver function
- GENITOURINARY: None blood in urine trouble urinating history of kidney stones
 waking up more than 3 times at night to urinate impaired kidney function
- MUSCULOSKELETAL: None red, hot swollen joints pain in joints arthritis
- NEUROLOGIC/PSYCHIATRIC: None seizures anxiety depression thoughts of suicide
- LYMPHATIC: Have you noticed any enlarged or swollen lymph nodes that won't go away? No Yes
 If yes, where? neck over the collar bones armpits borders between thigh and pelvis

ADDITIONAL HISTORY THAT YOU WANTED US TO KNOW: _____

