ALLERGY HISTORY QUESTIONNAIRE

Name: _________________________________________________________________ Date:_________________

Occupation: ___________________________________________________________________________________

Have you ever been tested for allergies? □ Yes □ No If yes, please answer the following:

By whom? (Include address, if possible) _____________________________________________________________
______________________________________________________________________________________________

Were you found to be allergic? □ Yes □ No

To what? ______________________________________________________________________________________

Were you treated with allergy shots? □ Yes □ No

For how long? __________________________________________________________________________________

Did the treatment help? □ Yes □ No

Section One – Symptoms

What are the main symptoms that brought you to the doctor? _______________________________________________
________________________________________________________________________________________________
________________________________________________________________________________________________

How long have these symptoms lasted? __________________________________________________________________

Did anything initiate the symptoms? ___________________________________________________________________

Does anything make the symptoms better or worse? _______________________________________________________
_________________________________________________________________________________________________

Are your symptoms worse in: □ Spring □ Summer □ Winter □ Fall

Please check the conditions below which apply to your symptoms:

A. Symptoms of Pollen Allergy
   □ Worse outdoors
   □ Worse on windy days
   □ Worse on sunny days
   □ Itching eyes
   □ Worse outdoors 7:00 to 11:00 am
   □ Better indoors
   □ Improved in air conditioning

B. Symptoms of Dust Allergy
   □ Worse indoors
   □ Improved outdoors
   □ Increased after going to bed or at night
   □ Recur or increase each year with the return of cold weather
   □ Nasal symptoms with little or no itching of the eyes
   □ Worse with air conditioning
   □ Increased in dust (such as in dusting or sweeping)
   □ Increased on exposure to cold air
C. Symptoms of Mold Allergy
- Worse outdoors between 4:30 and 8:30 pm
- Increased by cool evening air
- Worse while mowing or playing on grass
- Worse from mid-July to November
- Worse at damp or low places
- Distinctly aggravated in fall, winter
- Worse in coastal areas
- Worse on rainy days

D. Symptoms from Specific Contacts
- Worse in house after lights have been on an hour
- Worse in certain rooms: Which ones? ______________
- Worse in basement
- Worse around feed mills or barn
- React in a home with cats
- React in a home with dogs
- Worse in your house, but not in others
- Increased by drinking water

Please check any symptoms you are experiencing:

A. Respiratory
1. General
   - Pain
   - Nose bleeds
   - Loss of weight
   - Night Sweats
   - Temperature elevation
   - Tonsillitis
   - Frequent colds
   - Fatigue
   - Difficulty sleeping

2. Nasal Symptoms
   - Runny nose
   - Itching
   - Congestion
   - Intermittent
   - Constant
   - Daytime
   - Nighttime
   - After meals
   - With temperature change
   - Seasonal: Which ones? __________
   - Year-round

3. Cough
   - Seasonal
   - Year-round
   - Particular time of day
   - ___ am
   - ___ pm
   - Worse after colds
   - Productive
   - Color ______________
   - Consistency __________

4. Sneezing
   - Seasonal
   - Year-round
   - Upon waking up
   - At meals
   - After meals
   - In dust
   - In smoke

5. Breathing
   - Noisy
   - Wheezing
   - Daytime only
   - Nighttime only
   - Anytime
   - With exercise only
   - Seasonal: Which ones? __________

6. Voice
   - Hoarse
   - Intermittent
   - Constant
   - Worse as day progresses
   - Frequent laryngitis

B. Gastrointestinal
1. Mouth
   - Sore lips
   - Sore mouth
   - Sore tongue
   - Roof itches
   - Lip swelling

2. Stomach
   - Retasting food
   - Nausea
   - Vomiting
   - Cramps
   - Bloating

3. Throat
   - Sore
   - Scratchy
   - Lump in throat
   - Difficulty swallowing
4. Rectal
   □ Itching
   □ Pain

5. Appetite
   □ Good
   □ Selective
   □ Poor

C. Cardiovascular
1. Shortness of Breath
   □ Daytime
   □ Nighttime
   □ With exercise
   □ # of Pillows for sleep? ______

2. Swelling
   □ Face
   □ Hands
   □ Legs
   □ Time of day? ______

3. □ High Blood Pressure
4. □ Chest Pain
5. □ Heart or Pulse Irregular
6. □ Previous Heart Disease

D. Neurological
1. Headaches
   □ Age at onset ______
   □ Duration _________
   □ Frequency
     □ Regular
     □ Irregular
     □ At menses only
   □ Migraine

2. Ears
   □ Tinnitus or ear ringing
   □ Vertigo or dizziness
     □ Seasonal: Which ones? ______
     □ Year-round
     □ After eating: What foods? _____
     □ With weather change
     □ On windy days
     □ On overcast days
   □ Frequent infections
   □ Fluid behind eardrums
   □ Drainage

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   □ Drainage

F. Genitourinary
1. Urination
   □ Painful
   □ Delayed
   □ Prolonged
   □ Frequent
     □ Daytime
     □ Nighttime
     □ Bed Wetting

2. Eczema (dry, scaly skin)
3. Fungal Infection (nails, skin)

G. Skin
1. Rash
   □ Duration __________________
   □ Location
     □ Generalized (all over)
     □ Localized: Where? ______

2. Eczema (dry, scaly skin)
3. Fungal Infection (nails, skin)
Section Two – Environmental Exposures

### A. Home

<table>
<thead>
<tr>
<th>1. Type</th>
<th>2. Details</th>
<th>3. Region</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single house</td>
<td>Slab foundation</td>
<td>City, industrial</td>
</tr>
<tr>
<td>Duplex</td>
<td>Crawl Space</td>
<td>City, residential</td>
</tr>
<tr>
<td>Apartment: Floor?</td>
<td>Basement</td>
<td>Suburban</td>
</tr>
<tr>
<td>Hotel</td>
<td>Papered walls</td>
<td>Small town</td>
</tr>
<tr>
<td>Trailer</td>
<td>Sheet rock</td>
<td>Rural</td>
</tr>
</tbody>
</table>

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<tr>
<th></th>
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<tbody>
<tr>
<td>Central Heat</td>
<td>Washer: Location?</td>
<td>Outdoor plants: Location?</td>
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<tr>
<td>Gas</td>
<td>Dryer: Location?</td>
<td>Types?</td>
</tr>
<tr>
<td>Electric</td>
<td>Gas</td>
<td>Indoor plants: Location?</td>
</tr>
<tr>
<td>Central Air</td>
<td>Electric</td>
<td>Types?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>B. Chemicals in Home Use (Indicate Brand Name)</th>
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<tbody>
<tr>
<td>Roach chemical</td>
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<tr>
<td>Ant chemical</td>
</tr>
<tr>
<td>Chlorine cleansers</td>
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<tr>
<td>Household cleaners</td>
</tr>
<tr>
<td>Air fresheners</td>
</tr>
<tr>
<td>Aerosols</td>
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<tr>
<td>Exterminator service</td>
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<tr>
<td>Others</td>
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</tbody>
</table>

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<thead>
<tr>
<th>C. Animals and Birds (Indicate Type)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dog</td>
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<tr>
<td>Cat</td>
</tr>
<tr>
<td>Birds</td>
</tr>
<tr>
<td>Gerbil, hamster, mouse, etc.</td>
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<tr>
<td>Horse</td>
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<tr>
<td>Other</td>
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</tbody>
</table>

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<tr>
<th>D. Food</th>
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<tbody>
<tr>
<td>Vegetarian</td>
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<tr>
<td>Eat organic only</td>
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<tr>
<td>On a diet: Type?</td>
</tr>
<tr>
<td>Food cravings (describe)</td>
</tr>
<tr>
<td>Food sensitivities or reactions (list food and type of reaction)</td>
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</tbody>
</table>

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<thead>
<tr>
<th>D. Work</th>
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<tbody>
<tr>
<td>Symptoms worse at work</td>
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<tr>
<td>Symptoms improved at work</td>
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<tr>
<td>Foul odors or chemicals at work (describe)</td>
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<thead>
<tr>
<th>D. Check Any of the Following That Aggravate Your Symptoms</th>
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<tbody>
<tr>
<td>Paint fumes</td>
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<tr>
<td>Smoke</td>
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<tr>
<td>Cooking odors</td>
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<tr>
<td>Newspapers</td>
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<tr>
<td>Road dust</td>
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<td>Air pollution</td>
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<tr>
<td>Wool</td>
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<tr>
<td>Gasoline</td>
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<tr>
<td>Other</td>
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</table>
Section Three – Family History

Please indicate if any of your family members have had any of the following health problems:

<table>
<thead>
<tr>
<th></th>
<th>Father</th>
<th>Mother</th>
<th>Brother</th>
<th>Sister</th>
<th>Child</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hay Fever</td>
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<tr>
<td>Asthma</td>
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<tr>
<td>Hives</td>
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<tr>
<td>Eczema</td>
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<tr>
<td>Food Allergies</td>
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<td>Sinus Problems</td>
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<tr>
<td>Thyroid problems</td>
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<tr>
<td>Emphysema</td>
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<tr>
<td>Diabetes</td>
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<tr>
<td>Heart Problems</td>
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<tr>
<td>Cancer</td>
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Section Four – General Medical History

Please check any of the following medical conditions you are experiencing, or have experienced in the past:

- High blood pressure
- Heart disease
- Heart attack
- Arthritis
- Sinus disease
- Bronchitis
- Emphysema
- Asthma
- Hay Fever
- Nasal polyps
- Ulcers
- Stomach or intestinal disease
- Thyroid dysfunction
- Seizures
- Headaches
- Migraines
- Hives
- Skin disease
- Food allergies
- Cancer
- Fibromyalgia
- Chronic fatigue
- Diabetes

Please list all current prescription medications and dosages: __________________________________________________
__________________________________________________________________________________________________
__________________________________________________________________________________________________
__________________________________________________________________________________________________

Please list all current supplements (vitamins, minerals, etc.) and herbs: __________________________________________
___________________________________________________________________________________________________
___________________________________________________________________________________________________

Have you ever had a bad reaction to a medication?  □ Yes  □ No     If yes, please list the medication and reaction:
___________________________________________________________________________________________________

Do you smoke?  □ Yes  □ No     If yes, what do you smoke and how much? _________________________________

Do you drink alcohol?  □ Yes  □ No     If yes, what type and how much? _________________________________

□ Stopped smoking in ________      □ Stopped drinking in ________

□ Please check this box if there are any other issues you would like to discuss with the doctor, but do not feel comfortable reporting on this questionnaire.

Thank You!