Department of Otolaryngology / Head and Neck Surgery
Division of Allergy and Environmental Disease

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
  - ☐ Nightime
  - ☐ 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

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

3. Fatigue

- ☐ Upon waking up
- ☐ After meals
- ☐ Without exercise
- ☐ Constant

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
- ☐ Meniere's disease
- ☐ Hearing fluctuation
  - ☐ Seasonal: Which ones? _____
  - ☐ Year-round
  - ☐ After eating: What foods? _____
  - ☐ With weather change
  - ☐ On windy days
  - ☐ On overcast days
- ☐ Hearing loss: Which ears? _____
- ☐ Ear fullness or pressure
- ☐ Problems changing altitude

E. Musculoskeletal

1. ☐ Aching Muscles

2. ☐ Joint Pain

- ☐ Continuous
- ☐ Intermittent
- ☐ After meals
- ☐ Seasonal

3. ☐ Arthritis

4. ☐ Bursitis

F. Genitourinary

1. ☐ Urination

- ☐ Painful
- ☐ Delayed
- ☐ Prolonged
- ☐ Frequent
  - ☐ Daytime
  - ☐ Nighttime
  - ☐ Bed Wetting

G. Skin

1. ☐ Rash

- ☐ Duration _____

Location

- ☐ Generalized (all over)
- ☐ Localized: Where? _____

2. ☐ Eczema (dry, scaly skin)

3. ☐ Fungal Infection (nails, skin)

H. General

- ☐ Pain
- ☐ Night sweats
- ☐ Frequent colds
- ☐ Difficulty sleeping
- ☐ Nose bleeds
- ☐ Temperature elevation
- ☐ Fatigue
- ☐ Watery eyes
- ☐ Loss of weight
- ☐ Tonsillitis
- ☐ Fatigue
- ☐ Itchy eyes

Section Two – Environmental Exposures

A. Home

1. Type

- ☐ Single house
- ☐ Duplex
- ☐ Apartement: Floor? _____
- ☐ Hotel
- ☐ Trailer

2. Details

- ☐ Slab foundation
- ☐ Crawl Space
- ☐ Basement
- ☐ Papered walls
- ☐ Sheet rock
- ☐ Garage: Attached? _____

3. Region

- ☐ City, industrial
- ☐ City, residential
- ☐ Suburban
- ☐ Small town
- ☐ Rural

4. Heating and Ventilation

- ☐ Central Heat
  - ☐ Gas
  - ☐ Electric
- ☐ Central Air

5. Washer and Dryer

- ☐ Washer: Location? _____
- ☐ Dryer: Location? _____
  - ☐ Gas
  - ☐ Electric

6. Other

- ☐ Indoor plants: Location? _____
  - ☐ Types? _____
- ☐ Fireplace
  - ☐ Wood
  - ☐ Gas
- ☐ Feather or down pillows / comforter

B. Chemicals in Home Use (Indicate Brand Name)

- ☐ Roach chemical _____
- ☐ Ant chemical _____
- ☐ Chlorine cleansers _____
- ☐ Household cleaners _____
- ☐ Air fresheners _____
- ☐ Aerosols _____
- ☐ Exterminator service _____
- ☐ Others _____

C. Animals and Birds (Indicate Type)

- ☐ Dog _____
- ☐ Cat _____
- ☐ Birds _____
- ☐ Gerbil, hamster, mouse, etc. _____
- ☐ Horse _____
- ☐ Other _____

D. Food

- ☐ Vegetarian
- ☐ Eat organic only
- ☐ On a diet: Type? _____
- ☐ Food cravings (describe) _____
- ☐ Food sensitivities or reactions (list food and type of reaction) _____

D. Work

Describe your work location: _____

- ☐ Symptoms worse at work
- ☐ Symptoms improved at work
- ☐ Foul odors or chemicals at work (describe) _____

D. Check Any of the Following That Aggravate Your Symptoms

- ☐ Paint fumes
- ☐ Smoke
- ☐ Cooking odors
- ☐ Newspapers
- ☐ Road dust
- ☐ Air pollution
- ☐ Wool
- ☐ Gasoline
- ☐ Other _____

Section Three – Family History

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

	Father	Mother	Brother	Sister	Child
Hay Fever	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐
Hives	☐	☐	☐	☐	☐
Eczema	☐	☐	☐	☐	☐
Food Allergies	☐	☐	☐	☐	☐
Sinus Problems	☐	☐	☐	☐	☐
Thyroid problems	☐	☐	☐	☐	☐
Emphysema	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐
Heart Problems	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐

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!