



# Family Allergy Clinic

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*The American Board of Allergy and Immunology  
A conjoint board of the American Board of Internal Medicine  
and the American Board of Pediatrics*

## ALLERGY QUESTIONNAIRE

PATIENT: \_\_\_\_\_ TODAY'S DATE: \_\_\_\_\_ AGE: \_\_\_\_\_  
REASON FOR VISIT: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_ SEX: \_\_\_\_\_

My biggest worry about asthma or allergies is: \_\_\_\_\_  
My goal(s) for this visit include: \_\_\_\_\_  
My expectations for treatment are: \_\_\_\_\_  
Limitations I would like removed are: \_\_\_\_\_

**NATURE OF SYMPTOMS:** Fill in the blanks.

SYMPTOMS	# YEARS	WHICH MONTH(S)?	SYMPTOMS	# YEARS	WHICH MONTH(S)
SNEEZING	_____	_____	BAD BREATH	_____	_____
DRAINAGE	_____	_____	HEADACHES	_____	_____
ITCHY NOSE	_____	_____	FEVER	_____	_____
RUNNY NOSE	_____	_____	GREEN RUNNY NOSE	_____	_____
STUFFY NOSE	_____	_____	PRESSURE	_____	_____
ITCHY EYES	_____	_____	WHEEZING	_____	_____
RED EYES	_____	_____	CHEST TIGHTNESS	_____	_____
DRY EYES	_____	_____	FREQUENT COUGH	_____	_____
WATERY EYES	_____	_____	EXERCISE DIFFICULTY	_____	_____

**CAUSE OF SYMPTOMS:** Circle any suspected causes of symptoms.

INDOOR DUST	RAKING LEAVES	HIGH POLLEN COUNT	COLOGNE/PERFUME
CLEANING HOUSE	CUT GRASS	HIGH MOLD COUNT	WEATHER CHANGES
PETS/ANIMALS	HAY	ASPIRIN	CIGARETTE SMOKE
OUTDOORS	MOLD/MILDEW	WIND	ODORS

**PREVIOUS EVALUATION:** List dates of previous allergy tests/shots, sinus or chest X-rays or CT scans.

\_\_\_\_\_  
\_\_\_\_\_

**MEDICINES:** List ANY and ALL medicines you currently take.

1. \_\_\_\_\_ 4. \_\_\_\_\_ 7. \_\_\_\_\_  
2. \_\_\_\_\_ 5. \_\_\_\_\_ 8. \_\_\_\_\_  
3. \_\_\_\_\_ 6. \_\_\_\_\_ 9. \_\_\_\_\_

**MEDICINES:** List medications you previously took for allergies, and check where appropriate.

	COMPLETELY HELPFUL	PARTLY HELPFUL	NOT HELPFUL	UNSURE
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Name \_\_\_\_\_

**MEDICAL HISTORY:** Circle any other health problems.

ADHD      acid reflux    arthritis      enlarged prostate    heart failure      cataracts      chronic lung disease  
depression    diabetes      glaucoma      high cholesterol      high blood pressure    low thyroid      sleep apnea  
prematurity    other: \_\_\_\_\_

**ALLERGIES/REACTIONS TO MEDICATIONS:**

Drug/Non Drug	What Happened?
_____	_____
_____	_____
_____	_____

**PREVIOUS SURGERY:** Please list any nose or sinus first.

\_\_\_\_\_  
\_\_\_\_\_

**PREVIOUS HOSPITALIZATIONS:** Please list any asthma, sinus, or allergy related hospitalization first.

\_\_\_\_\_  
\_\_\_\_\_

**FAMILY HISTORY**

<u>Disease</u>	<u>Family Member/Relative</u>
Asthma	_____
Food allergies	_____
Eczema	_____
Nasal allergies	_____

**SOCIAL HISTORY**

Smoking: patient: \_\_\_\_\_ others at home \_\_\_\_\_  
Occupation: \_\_\_\_\_  
List work exposure to dust, chemicals, mold, or others: \_\_\_\_\_  
Hobbies: \_\_\_\_\_

**ENVIRONMENTAL SURVEY:** Please circle all that apply.

**LIVING ACCOMODATIONS**

House      Apartment  
Own      Rent    # Years \_\_\_\_\_

**BEDROOM**

Stuffed toys      Books  
Knick-knacks      Bookshelves

**ENERGY SOURCE**

Gas      Kerosene      Oil  
Coal      Electric      Wood

**FLOORING**

Carpet:    Entire house    Bedrooms  
Tile      Wood            Concrete

**TYPE PILLOW**

Feather/down      Foam  
Polyester            Synthetic

**AIR CONDITONING**

Central      Wall unit      None

**PETS**

Dogs    Cats    Birds  
Others \_\_\_\_\_

**MATTRESS**

Cotton stuffed  
Waterbed  
Foam Rubber

**COMFORTER**

Cotton  
Down

**OTHER**

HEPA filter      Electric air cleaner  
**DAYCARE/BABYSITTER**  
No    Yes/Where: \_\_\_\_\_

**REVIEW OF SYSTEMS:** Circle all that apply.

ALLERGY .....recurrent	ear infections	recurrent pneumonia	severe insect sting reactions
CONSTITUTIONAL .....fatigue	weight loss	loss of appetite	fever
ENT .....itchy nose	runny nose	sneezing	stuffy nose
	sore throat	loss of smell	
RESPIRATORY .....shortness of breath	chest tightness	wheezing	
	difficulty breathing	shortness of breath with exercise	
OPHTHALMALOLOGY .....itchy eyes	cough	watery eyes	
ENDOCRINE .....heat intolerance	glaucoma		
CARDIOLOGY .....chest pain	cold intolerance		
GASTROENTEROLOGY .....burping	irregular rhythm	abnormal chest sensations	
	nausea	diarrhea	
	vomiting	heartburn	
UROLOGY .....kidney stones	difficulty urinating	recurrent urinary infections	
DERMATOLOGY .....itching	swelling	hives	eczema
NEUROLOGY .....dizziness	headaches		seizures
HEMATOLOGY/LYMPH .....anemia	bleeding disorders	easy bruising	
MUSCULOSKELETAL .....muscle aches	joint swelling	joint pain	tendonitis
PSYCHOLOGIC .....anxiety	depression	high stress level	
FEMALE REPRODUCTIVE ....pregnant	frequent yeast infections		contraception