Diplomate
American Board of

Allergy and Immunology

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
_____	___	___	___	___
_____	___	___	___	___
_____	___	___	___	___
_____	___	___	___	___

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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

Disease	Family Member/Relative
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 CONDTIONING
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	itchy throat	loss of smell	
RESPIRATORY	shortness of breath	chest tightness	wheezing	
	difficulty breathing	cough	shortness of breath with exercise	
OPHTHALMALOGY	itchy eyes	glaucoma	watery eyes	
ENDOCRINE	heat intolerance	cold intolerance		
CARDIOLOGY	chest pain	irregular rhythm	abnormal chest sensations	
GASTROENTEROLOGY	burping	nausea	diarrhea	
	vomiting	heartburn		
UROLOGY	kidney stones	difficulty urinating	recurrent urinary infections	
DERMATOLOGY	itching	swelling	hives	eczema rash
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