Allergy & Asthma Treatment Center, PLC
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Date Filled: _____

ALLERGY-IMMUNOLOGY HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential. Please take your time to complete all 4 pages as applicable to your case.

Patient Name: *(Last, First, M.I.)*	☐ **M** ☐ **F**	**DOB** _____/_____/_____

Who is filling this questionnaire? Self Father Mother Other:

Marital Status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Please state the main reasons for this visit:

Primary care physician: **How did you find out about us?**

PERSONAL HEALTH HISTORY

Childhood Illness: ☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever

Immunizations: Any reactions to vaccines you have received?
Are immunizations up to date?

List Any Medical Problems that other Doctors have diagnosed:

Have you ever been evaluated for allergies (ie, skin tests) ☐ Yes ☐ No
If yes, please provide the results if available to you:

Were you treated with allergy shots? ☐ Yes ☐ No If Yes, for how long?

Did you miss any days from school or work in the last year because of your allergy or asthma symptoms?
☐ Yes ☐ No If Yes, how many? _____

Did you have any surgeries?

Other Hospitalizations:

List Allergies or other adverse reactions to Medications? Name the drug and describe the reaction:

List Your Prescribed Drugs and Over-the-Counter Drugs, Such as Inhalers, Vitamins and Herbal Remedies:

Drug name	Dose	Frequency Taken	Date started/stopped	Did the drug help?

FOOD ALLERGY: Do you have any allergies or adverse reactions to Foods? Please describe:

Skin:

Do you have any of the following? Check answer.
If Yes, mark an X for mild, XX for moderate and XXX for severe and describe:

Itching: ☐No ☐Yes Skin Rash: ☐No ☐Yes ñDry skinò? ☐No ☐Yes

History of eczema, childhood eczema or atopic dermatitis? ☐No ☐Yes:

Do you get hives or have had a history of hives? ☐No ☐Yes:

If yes, any known trigger for this problem?

How frequently do you get the hives?

How long do they last?

Ear:

Do you have a history of middle ear infections? ☐ Yes ☐ No If yes, give details:

Do you feel that your ears are plugged or have trouble hearing? ☐ Yes ☐ No

Eye:

Do you experience any of the following:
Itchy eyes: ☐No ☐Yes. If Yes, what time of the year?
Watery eyes: ☐No ☐Yes. If Yes, what time of the year?
If any known triggers for these symptoms, list here:

Tonsils & Sinus infections:

Do you have a history of recurrent tonsils or Strep throat infections ☐ Yes ☐ No

Do you have a history of sinus infections? ☐ Yes ☐ No How frequent?

Nasal and sinus symptoms:

Do you have any of the following? Check answer.
If Yes, mark an X for mild, XX for moderate and XXX for severe

Itchy nose: ☐No ☐Yes:
Runny nose: ☐No ☐Yes:
Sneezing: ☐No ☐Yes:
Congestion: ☐No ☐Yes:
Mouth breathing: ☐No ☐Yes:
Snoring: ☐No ☐Yes:
Post-nasal drip: ☐No ☐Yes:
Frontal or sinus headaches: ☐No ☐Yes:
Nose bleeding: ☐No ☐Yes:
Itchy, sore or scratchy throat: ☐No ☐Yes:
Frequent clearing of the throat: ☐No ☐Yes:

Any known trigger for the above symptoms, such as: (check all that apply)

☐ House dust ☐ Pet (dog, cat, etcé) ☐ Playing in or cutting the grass ☐ Hay
☐ Playing around trees ☐ Raking leaves ☐ Cold weather ☐ Weather changes
☐ Temperatures changes ☐ looking at the sun ☐ Moldy/mildew area (humid basement)
☐ Strong smells (perfumes, sprays) ☐ Cleaning agents ☐ Smoking, smog or smoke exposure
☐ Alcoholic beverages, specify:
☐ Aspirin and other pain killers, specify: ☐ Others, please specify:
☐ Foods, specify:

Breathing Symptoms:

Do you experience any of the following:
Deep cough: ☐No ☐Yes. If Yes, what time of the year?
Wheezing: ☐No ☐Yes. If Yes, what time of the year?
☐Yes, with colds or viral infections

If you answered Yes, are your symptoms noted? (Check what applies)
Several times a Day ☐ **Three to five days a week** ☐
One or two days a week ☐ **Once or twice a month** ☐ **Rarely: once every 3-4 months** ☐

Night symptoms: ☐No ☐Yes, if yes how frequently? é é é é é

Exercise-induced Symptoms:

How would you describe your activity level? (check one)
☐ Sedentary (No exercise) ☐ Mild Exercise (i.e., climb stairs, walk 3 blocks, golf)
☐ Occasional Vigorous Exercise (work or recreation, less than 4 times/week for 30 min.)
☐ Regular Vigorous Exercise (work or recreation 4 times/week for 30 minutes or more)

When exercising, do you experience any of the following?

1- **Cough**	☐ Yes, always	☐ Yes, sometimes	☐ No
2- **Wheezing**	☐ Yes, always	☐ Yes, sometimes	☐ No
3- **Chest tightness**	☐ Yes, always	☐ Yes, sometimes	☐ No

4- **Shortness of breath preventing you from keeping up with others** ☐ Yes ☐ No

Tobacco:

1- Tobacco use? ☐ Yes ☐ No ☐ Cigarettes - Packs/day _____ ☐ Pipe ☐ Cigars
Number of Years smoked _____ Year Quit, if apply _____
2- Second hand exposure to cigarette smoke? ☐ Yes ☐ No If yes. Where?

Lung infections:

History of pneumonia? ☐ Yes ☐ No

History of bronchitis? ☐ Yes ☐ No

Gastro-intestinal Symptoms:

Reflux Disease: Do you suffer from **heartburn**? ☐ Yes ☐ No
If patient is a child, any problems with vomiting or frequent regurgitation? ☐ Yes ☐ No
Any complaint of abdominal pain? ☐ Yes ☐ No
Any complaint of diarrhea or loose stools? ☐ Yes ☐ No

Allergy to insect bites:	Do you have any history of severe localized or generalized reactions to an insect bite (Bee, hornet, wasp, yellow jacket or other)? ☐ Yes ☐ No If yes, describe the reactions and give dates:

Home and Environmental Survey:

Do you live in a (circle what applies) house ranch style trailer apartment ? Age of dwelling:

Has the house ever been flooded? ☐ Yes ☐ No Do you have any room that is damp or musty? ☐ Yes ☐ No

Do you have a basement? ☐ Yes ☐ No Is it damp or musty? ☐ Yes ☐ No

Heating system (circle what applies): Forced air heating Fireplace Gas Stove Wood burning stove
Steam radiator Electric stove or radiator baseboard heating

Floors: Is the patientôs bedroom carpeted? ☐ Yes ☐ No
What about the rest of the house? Carpeted Vinyl Wood Laminate Tile

Where is the patientôs bedroom located? *First floor* *Second Floor* Are bunk beds used? ☐ Yes ☐ No
If patient is a child, do you keep stuffed toys in his/her bedroom? ☐ Yes ☐ No
What kind of pillow and comforter are used? Please specify:

Do you use air conditioning? ☐ Yes ☐ No If Yes, is it central or window unit?

Do you use a humidifier? ☐ Yes ☐ No If Yes, in what room?

Do you use a dehumidifier? ☐ Yes ☐ No Do you use air purifiers? ☐ Yes ☐ No

Plants inside the home? ☐ Yes ☐ No

Do you have pets? ☐ Yes ☐ No If Yes, specify:
Is the pet allowed in patientôs bedroom? ☐ Yes ☐ No
Are you exposed to pets other than at home? ☐ Yes ☐ No

What kinds of trees and shrubs are in the near vicinity of your home?

If applicable, briefly describe your work place:
Are you exposed at work to any chemicals or fumes? ☐ Yes ☐ No

Do you have any other exposures from hobbies or other recreational activities which can aggravate your condition?

Family History

	Name	Age	Specify below history of allergies, sinus, eczema, hives, asthma and as well as other health problems			Age	Specify below history of allergies, sinus, eczema, hives, asthma and as well as other health problems
Father				**Children**	☐ M ☐ F		
Mother					☐ M ☐ F		
Siblings	☐ M ☐ F				☐ M ☐ F		
	☐ M ☐ F				☐ M ☐ F		
	☐ M ☐ F				☐ M ☐ F		
	☐ M ☐ F				☐ M ☐ F		
	☐ M ☐ F				☐ M ☐ F		