ALLERGY QUESTIONNAIRE **DATE OF VISIT** ____/____/____

NAME: _____ **AGE:** _____ **DOB:** ____/____/____

Do you think you suffer from allergies? _____ Yes _____No

I. ALLERGY HISTORY

Skin Symptoms

1. **I have the following symptoms: (Circle all that apply and star the most troublesome one or ones):**

Itching	Redness	Bumpy texture of skin
Dryness	Swelling	Sensitivity to clothing or touch

Nasal Symptoms

2. **I have the following symptoms: (Circle all that apply and star the most troublesome one or ones):**

Nasal Congestion	Nasal itch / rubs	Bad breath
Fatigue / Irritability	Red eyes	Snoring
Post nasal drip	Itchy eyes	Mouth breathing
Runny nose	Sinus infections	Nosebleeds
Sneezing	Discolored drainage	Loss of Taste / Smell
Nasal polyps	Headaches	

Skin / Nasal Causes

3. **These things cause my symptoms: (Circle all that apply and star the most troublesome):**

Dust	Mold / Mildew	Time of day AM / PM
Fall Pollen	Mustiness / Dampness	Home
Spring Pollen	Indoors	Workplace
Cut grass / Raked leaves	Outdoors	Food _____
Dog	Weather changes	Rain
Cat	Smoke	Strong odors
Feathers	Temperature changes	

Other Animals _____

4. **My symptoms occur: (Circle one or both):** Year Round or Seasonally
   If seasonally, my symptoms occur in: (Month or Months): _____

5. **Have you had sinus x-rays or CT scan?** Yes No

II. RESPIRATORY HISTORY

1. **I have these symptoms:**

Cough	Cough from post nasal drip	Wheeze
Tightness	Symptoms with exercise	Shortness of breath

2. **I wake up at night because of chest symptoms:** Yes No

3. **My breathing problem is triggered by:**

Pollen	exercise	cold weather	sinus infections
Mold	heartburn	hot weather	pets
Foods	weather change / rain	other _____	

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III. MEDICATIONS

1. I take the following medications, including inhalers and nasal sprays:

NAME	DOSE	FREQUENCY USED
_____	_____	_____
_____	_____	_____

IV. ENVIRONMENTAL SURVEY

General

(CIRCLE WHERE APPROPRIATE)

1. Where do you live? House Apartment Trailer Condo
2. How long have you lived there? _____ How old is the dwelling? _____
3. Pets (if yes, specify):
   - Cat Indoor Outdoor Both
   - Dog Indoor Outdoor Both
   - Other Indoor Outdoor Both
4. Is there a smoker in the house? Yes No
5. Is the home air conditioned? Yes No
   (If yes, specify): central or window
6. Do you keep your windows opened? Yes No
7. Do you have moisture problems in your home? Yes No
8. Do you have a basement? Yes No

Bedroom

1. Type of bed? Regular Waterbed / Waveless Waterbed / Wave
2. Plastic encasement of mattress? Yes No
3. Type of pillow? Feather Synthetic Cotton
4. Do you have? Carpet Wood Vinyl Flooring

V. FAMILY HISTORY

1. Have you or anyone in your family been diagnosed with asthma? Yes No

VI. WEIGHT CONTROL AND NUTRITION HISTORY

1. I have the following symptoms: (Circle all that apply and star the most troublesome one or ones):

Shortness of breath	Increasing size	Lactose intolerance
Heartburn	Increasing weight	Loss of taste
Reflux	Increasing clothing size	Snoring
Food allergy		Excessively tired

Patients Signature: _____ **Date:** ____/____/____

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