# PATIENT ALLERGY QUESTIONAIRE

| NAME: | DOB: | SEX: | DATE: |
|---|---|---|---|
| | | | |

**CHIEF COMPLAINT:**

| 1. ARE YOU ALLERGIC TO ANY MEDICATION? : | 2. ARE YOU ALLERGIC TO THE FOLLOWING: |
|---|---|
| ◯ASPIRIN<br>◯PENICILLIN<br>◯OTHER MEDICATIONS:___________________________<br>_____________________________________________<br>EXPLAIN REACTION:___________________________________ | ◯BEE OR WASP STING<br>◯FIRE ANT<br>◯FOOD(LIST):____________________________________<br>_______________________________________________<br>◯LATEX<br>EXPLAIN REACTION: _______________________________ |

| PAST MEDICAL HISTORY: (CHECK ALL THAT APPLY) | SURGICAL HISTORY :(LIST ALL SURGERIES) |
|---|---|
| **3. DO YOU HAVE OR HAVE HAD:**<br>◯NASAL ALLERGIES ◯ THYROID DISEASE<br>◯ASTHMA ◯ HIGH BLOOD PRESSURE<br>◯ECZEMA ◯ ENLARGED PROSTATE<br>◯REFLUX ◯ LIVER DISEASE<br>◯DIABETES ◯ HEART DISEASE<br>◯GLAUCOMA ◯KIDNEY DISEASE<br>◯OSTEOPOROSIS<br>◯OTHER______________________ | ◯SINUS SURGERY ◯ADENOID REMOVAL<br>◯EAR TUBES ◯NASAL POLYP REMOVAL<br>◯TONSIL REMOVAL<br>◯OTHER___________________<br>(PLEASE CIRCLE YES OR NO)<br>4. HAVE YOU EVER BEEN ALLERGY TESTED BEFORE?**YES/NO**<br>5. DID YOU RECEIVE ALLERGY SHOT TREATMENT? **YES/NO** |

| HOSPITALIZATION HISTORY: | PEDIACTRIC SECTION: |
|---|---|
| 6. HAVE YOU BEEN HOSPITALIZED?(CIRCLE) **YES NO**<br>◯ASTHMA ◯PNEUMONIA ◯ANAPHYLAXIS<br>OTHER____________________________________ | NEWBORN HISTORY (CIRCLE YES OR NO)<br>7. PREMATURE? **YES/NO**<br>8. IMMUNIZATION UP TO DATE? **YES/NO**<br>9. INFANT BREAST FEEDING? **YES/ NO**<br>10. FAILURE TO THRIVE? **YES/ NO** |

| FAMILY HISTORY:(CHECK ALL THAT APPLY) | ENVIRONMENTAL HISTORY: (CHECK ALL THAT APPLY) |
|---|---|
| **11. DOES ANYONE IN YOUR FAMILY HAVE:**<br>◯ASTHMA ◯FOOD ALLERGIES<br>◯ALLERGIES ◯SWELLING<br>**12. SMOKING STATUS:**<br>◯NEVER SMOKED<br>◯CURRENT SMOKER<br>◯PREVIOUS SMOKER<br>◯OTHER SMOKERS IN THE HOUSE | **13. TYPE OF HOME:**<br>◯HOME ◯APARTMENT<br>**14. TYPE OF FLOORING:**<br>◯TILE ◯WOOD<br>◯CARPET ◯AREA RUGS<br>**15.BEDDING: (YES/ NO)**<br>◯DUST MITE COVERS<br>◯DRAPES/ CURTAINS<br>◯FEATHER PILLOWS<br>**16. AIR CONDITIONING:**<br>◯CENTRAL ◯WINDOW<br>**17.DO YOU HAVE ANY PETS?** _______________<br>**18. DOES YOUR HOME HAVE OR HAD ANY WATER LEAKS?**<br>_____________________ |

______________________________ PATIENT/GUARANTOR'S SIGNATURE

Allergy Consultants
Robert Schramm, M.D.

______________________________ DATE