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Board Certified
Allergy & Immunology

REVIEWED WITH PATIENT



Longmont Clinic

ALLERGY QUESTIONNAIRE

Patient's Name		ID#	Date of Birth	Age
Address		City/State/Zip		
Date of Appointment	Referring Physician	Home Telephone	Work Telephone	

1. INSTRUCTIONS: Please answer the questions as they relate to the person being evaluated. A complete, accurate record is important in learning about your allergy problem. Bring this completed form to your first appointment.

Briefly describe the reason for your allergy visit and what you hope to accomplish. _____

2. PROBLEMS: Have you ever had the following conditions? Please check all items.

YES	NO	CONDITION	AGE AT ONSET	SEVERITY			COMMENTS
				MILD	MOD.	SEV.	
		Asthma (wheezing)					
		Any other breathing problems					
		Sinus trouble					
		Sinus surgery					
		Hay fever (runny, stuffy, itchy nose; sneezing)					
		Hives or swelling					
		Eczema or other rashes					
		Frequent infections					
		Food reactions					
		Drug reactions					
		Insect reactions					

3. SYMPTOMS: Have you ever had any of the following? If not, leave blank.

	HOW MANY DAYS IN THE LAST MONTH?	SEVERITY			CIRCLE THE MONTHS MOST SEVERE
		MILD	MOD.	SEV.	
Runny nose					J F M A M J J A S O N D
Stuffy nose					J F M A M J J A S O N D
Yellow/green mucus from nose					J F M A M J J A S O N D
Itchy nose					J F M A M J J A S O N D
Sneezing					J F M A M J J A S O N D
Itchy eyes					J F M A M J J A S O N D
Wheezing					J F M A M J J A S O N D
Coughing					J F M A M J J A S O N D
Wheezing or coughing with exercises					J F M A M J J A S O N D
Night waking with cough/wheeze					J F M A M J J A S O N D
Acid taste in mouth					J F M A M J J A S O N D
Heartburn					J F M A M J J A S O N D
Skin problem					J F M A M J J A S O N D

PHYSICIAN'S NOTES:

4. SEVERITY OF SYMPTOMS		
ITEM	NO	YES (EXPLAIN)
Have symptoms ever limited your activity at school or work? ...		
Have you lost time from school or work?		
Have you ever made emergency room visits for your chest symptoms?	Most Recent	
	Total Number	
Have you ever been hospitalized for your chest symptoms?	Dates:	

5. PRECIPITATING FACTORS/ TRIGGERS: For each item below, check the appropriate square to indicate whether the condition is affected by the following precipitants/triggers. Indicate "N" for Nasal, "C" for Chest, "S" for Skin.

	CONDITION MADE WORSE			CONDITION IMPROVED			NO CHANGE		
	MADE WORSE	CONDITION IMPROVED	NO CHANGE	MADE WORSE	CONDITION IMPROVED	NO CHANGE	MADE WORSE	CONDITION IMPROVED	NO CHANGE
Cutting or playing in grass, raking leaves	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other strong odors. Specify: _____					
High winds, riding in auto	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Exposure to animals. Specify: _____					
Other outdoor exposure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	"Colds" or viruses					
Moldy/mildewed areas or items (basement, attic, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Physical exertion or exercise					
Sweeping, dusting or vacuuming	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cold weather					
Smog, smoking or smoke, smoke exposure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other factors _____					
Tobacco smoke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Medications:					
Air conditioning or heating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Antihistamines or cold preparations					
Cleaning agents, detergents, ammonia, bleach, soap, conditioner, shaving cream, toothpaste, etc. Specify: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Asthma medications					
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nose drops or spray					
Paint lacquer, glue, mothballs, motor fumes, chemicals, fertilizers, insect spray, cooking odors, etc. Specify: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Aspirin					
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other _____					
				Problems with:					
				Yes		No			
				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		

6. FOOD REACTIONS: Have you ever had any symptoms (rash, hay fever, vomiting, gas cramps, diarrhea, colic as an infant) after the ingestion of any food or liquid? If yes, specify below.

FOODS	SYMPTOMS	CAN FOOD BE EATEN?		DATE FOOD WAS LAST EATEN
		YES	NO	

7. SMOKING

Have you ever smoked? Yes No If yes, how many years? _____

Do you currently smoke? Yes No When did you stop? _____

Average cigarettes per day at highest point? _____ If you still smoke, do you think you could stop? Yes No

Which other family members now smoke? _____

8. FAMILY HISTORY

Do any members of your family have a history of allergy?			If yes, list relatives	Is there a family history of any other illnesses?			If yes, list relatives
	YES	NO			YES	NO	
Asthma				Emphysema or other lung disease			
Hay fever				Cystic fibrosis			
Eczema				Tuberculosis			
Hives				Thyroid disease			
Swelling				Glaucoma			
Frequent pneumonia				Diabetes			
Headaches				Other			
Other allergies							

9. RESIDENCE: List your past residences with your most recent first. Only the city and the state are required.

CITY & STATE	# OF YEARS	EFFECT ON SYMPTOMS (BETTER, WORSE, NO CHANGE)
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____

10. ENVIRONMENTAL SURVEY

Where do you live (city or rural)?		Number of indoor plants:			
Age of house: _____ years		House construction (brick, wood, etc.):			
Are any rooms damp or musty?		Do you have (a) an air cleaner? (b) an air humidifier?			
Type of heating (forced air, steam, space-heater, baseboard, electric, etc.):		Type of air conditioning (central, window, etc.):			
	Bedrooms	Living room	Den	Dining Room	
Type of Carpet (wool, synthetic, jute)					
And Pad (rubber, ozite, hair)					
How old is your pillow? _____ mattress?		Do you have any stuffed furniture? _____ leather comforters?			
Is your pillow: <input type="checkbox"/> feather <input type="checkbox"/> foam rubber <input type="checkbox"/> dacron <input type="checkbox"/> other _____ <input type="checkbox"/> encased in plastic		Is your mattress: <input type="checkbox"/> foam rubber <input type="checkbox"/> cotton <input type="checkbox"/> innerspring & cotton <input type="checkbox"/> waterbed <input type="checkbox"/> encased in plastic <input type="checkbox"/> other _____			
What kind of grasses, shrubs, and trees are in the immediate vicinity of your house?					
Do you have pets? List number and kind (dog, cat, birds, horses, etc.):		Do your pets spend time indoors? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Are there smokers in your house?					
What type of work do you do?					
Are you exposed to anything at work that might aggravate your condition? Which things?					
Have you missed any time from work or school because of your allergies? How much time?					
Do you have any other exposures from hobbies, recreational activities, etc.?					

11. PREVIOUS ALLERGY EVALUATION AND THERAPY

Have you ever had allergy skin tests?
 Yes No If yes, give dates _____ Physician's name _____
 Results of these tests (if possible, please provide us with a copy):

Have you ever received allergy injections?
 Yes No If yes, give dates: _____ Did they help? Yes No

Please list all medications that you are now taking. Bring all these with you to your first appointment.

NAME	DOSAGE	# TIMES/DAY	DOES THIS HELP?

Please list all medications you have taken for allergies in the past.

NAME	DOSAGE	# TIMES/DAY	DID THIS HELP?

12. OTHER MEDICAL PROBLEMS: Have you ever had any of the following? Please answer all items.

	YES	NO		YES	NO		YES	NO
Frequent headaches	<input type="checkbox"/>	<input type="checkbox"/>	Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	Kidney or bladder trouble	<input type="checkbox"/>	<input type="checkbox"/>
Frequent nosebleeds	<input type="checkbox"/>	<input type="checkbox"/>	number in past year: _____			Liver trouble (e.g., hepatitis)	<input type="checkbox"/>	<input type="checkbox"/>
Nasal polyps	<input type="checkbox"/>	<input type="checkbox"/>	Coughed up blood	<input type="checkbox"/>	<input type="checkbox"/>	Frequent diarrhea	<input type="checkbox"/>	<input type="checkbox"/>
Operation on sinuses	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Sexual problems	<input type="checkbox"/>	<input type="checkbox"/>
Sinus X-rays	<input type="checkbox"/>	<input type="checkbox"/>	Chest X-ray	<input type="checkbox"/>	<input type="checkbox"/>	Bedwetting	<input type="checkbox"/>	<input type="checkbox"/>
Ear Infections	<input type="checkbox"/>	<input type="checkbox"/>	Heart trouble	<input type="checkbox"/>	<input type="checkbox"/>	Poison ivy/oak	<input type="checkbox"/>	<input type="checkbox"/>
number in past year: _____			High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid disorder	<input type="checkbox"/>	<input type="checkbox"/>
Hearing problems	<input type="checkbox"/>	<input type="checkbox"/>	Colic or spitting up as an infant	<input type="checkbox"/>	<input type="checkbox"/>	Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Frequent heartburn	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Tonsils/Adenoids	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>			
date removed: _____								

13. HOSPITALIZATIONS: List most recent first.

REASON	DATE
1. _____	_____
2. _____	_____
3. _____	_____

14. SURGERY: List most recent first.

REASON	DATE
1. _____	_____
2. _____	_____
3. _____	_____

15. EDUCATION/OCCUPATION

Grade school (highest grade) ____ High school 1 2 3 4
 College 1 2 3 4 Grad school/area: _____
 Occupation _____

16. LIVING ARRANGEMENTS

Married Single Roommates
 Widowed Separated Domestic partner
 No. of children: _____

17. PERSONAL CHARACTERISTICS

How would you describe yourself (or your child if he/she is being evaluated)? Check those that apply.

<input type="checkbox"/> Timid	<input type="checkbox"/> Tense	<input type="checkbox"/> Concerned	<input type="checkbox"/> Shy
<input type="checkbox"/> Quiet	<input type="checkbox"/> Calm	<input type="checkbox"/> Depressed	<input type="checkbox"/> Relaxed
<input type="checkbox"/> Aggressive	<input type="checkbox"/> Well-adjusted	<input type="checkbox"/> Bustling	<input type="checkbox"/> Independent
<input type="checkbox"/> Forward	<input type="checkbox"/> Few friends	<input type="checkbox"/> Happy	<input type="checkbox"/> Manipulative
<input type="checkbox"/> Unfriendly	<input type="checkbox"/> Spoiled	<input type="checkbox"/> Anxious	<input type="checkbox"/> Extrovert
<input type="checkbox"/> Introvert	<input type="checkbox"/> Dependent	<input type="checkbox"/> Many friends	<input type="checkbox"/> Usually ill

For Physician's Use Only: Physical Exam

HT:	WE:	BP:	P:	R:	T:	FEV ₁ :	GROWTH CHART %TILE
General _____			Ears _____			Lungs _____	
Skin _____			Nose _____			Other _____	
Head _____			Throat _____				
Eyes _____			Nodes _____				