ALLERGY QUESTIONNAIRE

Patient Name: _____ **Date:** _____

Address: _____ **Date of Birth:** _____

City, State, Zip: _____ **Home#:** _____

Gender (circle one): **MALE** **FEMALE** **Work#:** _____

Primary Care Physician: _____ **Referring Physician:** _____

How were you referred you to our office, if not by your Physician? _____

Although your history and symptoms are very important in our analysis of your condition, it is also important for us that you understand:

- *We do not treat symptoms or diseases.*
- *Allergy is not a disease, rather a condition.*
- *A symptom is an attempt by your body to tell you something.*
- *We will attempt to find the underlying cause.*
- *We do not use drugs in this program.*
- *There is no single "healthy" diet that will work for everyone.*
- *Just because food is considered "healthy", does not mean it is "healthy" for you.*
- *Your diet consists of everything you **eat, drink, rub on your skin, or inhale**.*
- *Our procedures are safe and painless.*

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

_____

AGE WHEN SYMPTOMS WERE FIRST OBSERVED

__ Infant (Age 0-2)
__ Child (Age 3-5)
__ Child (Age 6-12)
__ Adolescent (Age 13-18)
__ Adult (Age 19-25)
__ Adult (Age 26-40)
__ Adult (Age 41 and over)

DID YOU SUFFER FROM ANY TYPE OF PHYSICAL, CHEMICAL OR EMOTIONAL TRAUMA JUST BEFORE YOUR SYMPTOMS WERE FIRST OBSERVED? _____

HAVE YOUR SYMPTOMS EVER GONE AWAY FOR ANY PERIOD OF TIME? _____

PREVIOUS DIAGNOSIS OF ALLERGY

__ Yes and allergy shots helped
__ Yes but allergy shots did not help
__ Yes and medication helped
__ Yes but medication did not help
__ None

PLEASE CHECK OFF THE FOLLOWING THAT APPLY TO YOU:

Digestive Track
__ nausea & vomiting
__ diarrhea
__ constipation
__ bloated feeling
__ stomach pains or cramps
__ heart burn
__ blood and/or mucous in stools

Ears
__ itchy ears
__ ear aches/ear infections
__ drainage from ear
__ ringing in ears
__ hearing loss
__ reddening of ears

Emotions
__ mood swings
__ anxiety/fear/nervousness
__ anger/irritability/aggressiveness
__ argumentative
__ frustrated/cries easily
__ Depression *****

Eyes
__ watery or itchy eyes
__ red/swollen/itchy eyelids
__ bags or dark circles under eyes
__ blurred or tunnel vision

Head
__ headaches
__ migraines
__ faintness
__ dizziness
__ insomnia/sleep disorder
__ facial flushing

Heart
__ Irregular/Skipped Heartbeat *****
__ Rapid/Pounding Heartbeat*****
__ Chest Pain *****

Joints & Muscles
__ pains/aches in joints
__ back pain
__ neck pain
__ disc problems
__ arthritis/osteoarthritis
__ stiffness/limited movement
__ pain/aches in muscles
__ feeling weak/tired
__ swollen/tender joints
__ growing pains in legs
__ Psoriatic/Gouty Arthritis *****
__ Rheumatoid Arthritis *****

Lungs
__ chest congestion
__ bronchitis
__ shortness of breath
__ difficulty breathing
__ persistent cough
__ wheezing

Mind
__ poor memory
__ difficulty completing projects
__ difficulty with mathematics
__ underachiever
__ poor/short attention span
__ confusion
__ easily distracted
__ difficulty making decisions
__ mild learning Disabilities

Mouth & Throat Thrush
__ chronic coughing
__ gagging/clearing throat often
__ sore throat/hoarse voice/voice loss
__ swollen/discolored tongue/lips
__ canker sores
__ itching on roof of mouth

Nose
__ stuffy nose
__ chronically red/inflamed nose
__ sinus problems
__ hay fever
__ sneezing attacks
__ excessive mucous formation

Skin
__ acne
__ itching
__ hives/rash/dry skin
__ hair loss
__ flushing/hot flashes

Weight
__ binge eating/drinking
__ craving certain foods
__ excessive weight
__ compulsive eating
__ water retention

General
__ frequent illness
__ frequent/urgent urination
__ genital itch/discharge
__ anal itching

Genitourinary
__ kidney problems
__ urinary tract
__ bladder
__ yeast infections
__ menstrual irregularity

Other Conditions
__ Autism ******
__ A.D.H.D. *****
__ A.D.D. *****
__ Psoriasis *****
__ Eczema *****
__ Auto-Immune Disorder *****
__ Chronic Fatigue *****
__ Multiple Chemical Sensitivities *****
__ Asthma *****
__ Congestive Heart Failure *****
__ Severe Diabetic *****
__ Severe Depression *****
__ Obsessive Compulsive Disorder *****

FAMILY MEMBERS WITH ALLERGIC SYMPTOMS

__ Mother __ Father
__ Brother/Sister __ Grandparents
__ Son/Daughter __ Spouse
__ None

FREQUENCY & SEVERITY OF ALLERGY SYMPTOMS

__ Constant/Chronic with little change __ Present most of the time
__ Present part of the time __ Present rarely
__ Prevents some normal activities __ Considerable interference with normal life
__ Slight interference with normal life __ No interference with normal life

SYMPTOMS ARE WORSE

__ Outdoors and better indoors __ At nighttime
__ In the bedroom or when in bed __ During windy weather
__ During wet or damp weather __ When the weather changes
__ During known pollen seasons __ In certain rooms or buildings
__ When exposed to tobacco smoke __ With yard work, cut grass, leaves, hay or barns
__ When sweeping or dusting the house __ In areas with mold or mildew
__ In air conditioning __ In fields or in the country
__ Tobacco smoke bothers me more than anything else

SYMPTOMS ARE BETTER

__ After shower or bath __ In air conditioning
__ Indoors __ During or after physical activity
__ After taking antihistamines __ With allergy shots

What makes you feel better? _____

_____

ANIMALS, INSECTS AND BIRDS THAT CAUSE SYMPTOMS ON EXPOSURE

__ Dogs __ Cats __ Rodents (mice, guinea pigs, etc.)
__ Horses or Cattle __ Rabbits __ Birds or Feathers
__ Bees __ Other _____
__ None

FOOD RELATED SYMPTOMS

__ Symptoms flare 5-60 minutes after meals __ Some foods are craved or addictive
__ The smell or odor of some foods increases symptoms __ Some foods cause nasal symptoms
__ Some foods cause swelling of the mouth or tongue __ Some foods cause rashes or hives
__ Some foods cause upset stomach or vomiting __ Some foods cause diarrhea
__ Symptoms occur with restaurant salad bars or Asian foods __ Some foods cause headaches
__ Symptoms occur with any regularly eaten food __ Some foods cause asthma
__ Preservatives, additives or food coloring increase symptoms __ No problem with foods

FOODS THAT CAUSE SYMPTOMS FROM ONE HOUR TO THREE DAYS AFTER EXPOSURE

__ Eggs __ Milk __ Beef
__ Corn __ Wheat __ Soybean
__ Peanut __ Pork __ Fish
__ Shellfish __ Orange or other citrus __ Potato
__ Tomato __ Yeast __ Chocolate
__ Coffee or Tea __ Other _____
__ None

CHEMICALS THAT CAUSE SYMPTOMS

__ Insecticides & pesticides __ Paints & household cleaners
__ Perfumes & cosmetics __ Gasoline or automobiles exhaust
__ Stove or furnace emissions __ The smell of new fabrics or fabric store
__ Chemicals in the workplace __ Laundry detergent
__ Newsprint __ Other: _____
__ None

WHEN ARE YOUR SYMPTOMS WORSE

__ Year around
__ January __ February __ March __ April
__ May __ June __ July __ August
__ September __ October __ November __ December

MEDICATIONS

Do you take any of the following medications on a regular basis?

__ Antihistamines (Benadryl, Actifed, Chlortrimeton, Tylenol Sinus, Tylenol Sleep, Dimetapp,Drixoral, Trimalin, Atarax, Claritin, Allegra, Zyrtec, etc)
__ Bronchodilators (Albuterol, Ventolin, Proventil, Serevent, or OTS's such as Primatine Mist, etc)
__ Steroid Inhalers (Asmacort, Flovent, Pulmicort, Beclovent, Aerobid, Advair, etc)
__ Nasal Steroids (Beconase, Flonase, Nasacort, Rhinocort, etc)
__ Medications that affect the immune system (Prednisone, Imuran, Methotrexate, Cellcept, Cyclosporine, Tacrolimus, etc)
__ Chemotherapy

Please list any medications that you are currently taking: _____

_____

SMOKING

Do you presently smoke? Yes No If yes, average number of cigarettes per day _____

If yes, at what age did you start? _____

Does anyone smoke in your home? Yes No

PREVIOUS ALLERGY EVALUTION

Have you ever seen an allergist? Yes No
Have you had allergy skin testing? Yes No
Did you have any positive reaction? Yes No
If yes, please list positive allergens (include any medications)

_____

Have you ever received allergy injections? Yes No

WORK ENVIRONMENT

What is your occupation? _____

Are you exposed to chemicals or strong odors at work? Yes No

If yes, briefly explain _____

_____

Are you symptoms worse while at work? Yes No

If yes, briefly explain _____

_____

ANY ADDITIONAL INFORMATION YOU WOULD LIKE US TO KNOW? _____

_____

_____

_____

_____

_____

ANYTHING ELSE YOU WOULD LIKE TO ASK? _____

_____

_____

_____

_____

_____