Carlos J. Piniella, M.D., FACAAI
Diplomat American Board and Pediatric Allergy Asthma and Immunology

ALLERGY QUESTIONNAIRE

Name	Date of Birth
Date of Appointment	**Referring Physician**

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 for your first appointment.

1. HISTORY OF YOUR PRESENT ILLNESS

What is the chief problem that brings you to see the doctor? _____

When did your problem start? _____

How many times has your problem occurred? _____

When was the last time you had problems? _____

When you have a problem, how long does it last? _____

Is it worse at any certain time of day, week, or year? (Check all that apply)

❑ **AM** ❑ **PM** ❑ **Weekday** ❑ **Weekend** ❑ **Spring** ❑ **Summer** ❑ **Fall** ❑ **Winter** ❑ **Other** _____

Is there anything that seems to trigger your problem? (Check all that apply)

❑ **Grass** ❑ **Dust** ❑ **Mold** ❑ **Cleaning** ❑ **Solutions** ❑ **Smoke** ❑ **Perfume** ❑ **A/C** ❑ **Heat**
❑ **Fans** ❑ **Cat** ❑ **Dog** ❑ **Other** _____

Is there anything that improves your problem? (Check all that apply)

❑ **Antihistamines** ❑ **Decongestants** ❑ **Nasal Steroids** ❑ **Nasal Decongestants** ❑ **Oral Steroids** ❑ **Antibiotics**
❑ **Albuterol** ❑ **Inhaled Steroids** ❑ **Other** _____

How severe is your problem when it occurs? ❑ **Mild** ❑ **Moderate** ❑ **Severe** ❑ **Very Severe**

Are there other associated symptoms that occur? _____

2. PROBLEM

Do you have any of the following:

Runny nose	❑ YES	❑ NO	Wheezing	❑ YES	❑ NO
Stuffy nose	❑ YES	❑ NO	Shortness of breath	❑ YES	❑ NO
Post nasal drip	❑ YES	❑ NO	Coughing	❑ YES	❑ NO
Itchy nose	❑ YES	❑ NO	Wheezing or coughing with exercise	❑ YES	❑ NO
Sneezing	❑ YES	❑ NO	Chest tightness	❑ YES	❑ NO
Itchy eyes	❑ YES	❑ NO	Eczema / Rash	❑ YES	❑ NO
Sinus Headaches	❑ YES	❑ NO	Hives	❑ YES	❑ NO

3. PAST ALLERGY PROBLEMS

Have you ever had the following conditions?

			Age of Onset	Comments
Asthma (Wheezing)	❑ YES	❑ NO		
Anaphylaxis	❑ YES	❑ NO		
Use of Inhalers / Nebulizers	❑ YES	❑ NO		
Any Other Breathing Problems	❑ YES	❑ NO		
Sinus Trouble	❑ YES	❑ NO		
Sinus Headaches	❑ YES	❑ NO		
Hay Fever (Runny, stuffy, itchy nose, sneezing)	❑ YES	❑ NO		
Hives or swelling	❑ YES	❑ NO		
Eczema or Other Rashes	❑ YES	❑ NO		
Frequent Infections	❑ YES	❑ NO		
Food Reactions	❑ YES	❑ NO		
Drug Reactions	❑ YES	❑ NO		
Insect Reactions	❑ YES	❑ NO		
Bronchitis	❑ YES	❑ NO		
COPD/Emphysema	❑ YES	❑ NO		

Name _____

4. PREVIOUS ALLERGY EVALUATION AND THERAPY

Have you ever had allergy skin tests? ❑ Yes ❑ No If yes, date _____ 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 _____

Please list all medications that you are currently taking - name, dosage, number of times a day. Bring all these with you for your first appointment.

Medication Name & Dosage	Number of Times a Day	Medication Name & Dosage	Number of Times a Day

Please list all Drug allergies & type of reaction: _____

5. PAST MEDICAL HISTORY

Have you ever had any of the following? Answer all items.

High Blood Pressure	❑ YES ❑ NO	Cancer	❑ YES ❑ NO	Depression	❑ YES ❑ NO
Emphyzema/Chronic Bronchitis	❑ YES ❑ NO	Pneumonia	❑ YES ❑ NO	Asthma	❑ YES ❑ NO
Heart Attacked/Heart Disease	❑ YES ❑ NO	High Cholesterol	❑ YES ❑ NO	Stroke	❑ YES ❑ NO
Reflux/Stomach Ulcers	❑ YES ❑ NO	Other	❑ YES ❑ NO	Other	❑ YES ❑ NO

6. SURGERIES

Check all that apply.

❑ Tonsils ❑ Adenoids ❑ Sinus ❑ Cataract ❑ C-Section ❑ Hysterectomy

❑ Appendix ❑ Gall Bladder ❑ Nasal Polyps ❑ Ear Tubes

❑ Other _____

7. ENVIRONMENTAL SURVEY

Where do You Live: ❑ House ❑ Apartment ❑ Mobile Home **Occupation**:

Main Area Flooring: ❑ Carpet ❑ Wood ❑ Tile **Bedroom Flooring:** ❑ Carpet ❑ Wood ❑ Tile

Air Ventilation (Main Area): ❑ A/C (central unit) ❑ A/C (wall unit) ❑ Fans

Air Ventilation (Patient's Bedroom): ❑ A/C (central unit) ❑ A/C (wall unit) ❑ Fans ❑ Stuffed Animals ❑ Curtains ❑ Book Case ❑ Blinds ❑ Dust Covers

Any Pets in the Home or Regular Contact (1x / week or more): ❑ Dog ❑ Cat ❑ Rabbit ❑ Hampsters ❑ Horses ❑ Birds ❑ Others

Name _____

8. FAMILY HISTORY (e.g. parents, siblings, aunts, uncles, grandparents, first cousins)

Asthma	❑ YES ❑ NO	Emphysema	❑ YES ❑ NO
Hay Fever	❑ YES ❑ NO	Cystic Fibrosis	❑ YES ❑ NO
Eczema	❑ YES ❑ NO	Tuberculosis	❑ YES ❑ NO
Hives	❑ YES ❑ NO	Glaucoma	❑ YES ❑ NO
Swelling	❑ YES ❑ NO	Diabetes	❑ YES ❑ NO
Frequent Pneumonia	❑ YES ❑ NO	Other	❑ YES ❑ NO
Headaches	❑ YES ❑ NO		
Other Allergies	❑ YES ❑ NO		

9. SOCIAL HISTORY

Marital Status: ❑ Single ❑ Married ❑ Div. ❑ Widowed ❑ Separated | **Children:** ❑ N/A ❑ 0 ❑ 1 ❑ 2 ❑ 3 ❑ More

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

Do you presently smoke? ❑ Yes ❑ No ❑ If No, when did you stop? _____

Average cigarettes per day at highest point? ❑ <1/2 pack/day ❑ 1/2-1 pack/day ❑ 1 pack/day ❑ 1 1/2-2 packs/day ❑ >2 packs/day

Are there friends or family who now smoke inside the home? ❑ Yes ❑ No

Do you drink alcoholic beverages? ❑ No ❑ Yes ❑ 1-2 drinks/week ❑ 2-5 drinks/week ❑ > 6 drinks/week

Education (check the highest level completed): ❑ Grade School ❑ High School ❑ College ❑ Graduate School ❑ Professional ❑ Technical

10. REVIEW OF SYSTEMS

Eyes:	❑ Burning ❑ Itching ❑ Discharge ❑ Tearing Dry Eyes ❑ Red Eyes ❑ Dark Circles
Ears:	❑ Ringing ❑ Pain ❑ Pressure ❑ Hearing Decrease ❑ Infections
Nose:	❑ Decreased Sense of Smell ❑ Sneezing ❑ Runny Nose ❑ Stuffy Nose ❑ Itchy Nose ❑ Nosebleeds ❑ Snoring
Throat:	❑ Difficulty Swallowing ❑ Pain or Soreness ❑ Decreased Taste ❑ Hoarseness
Respiratory:	❑ Cough Wheezing ❑ Chest Tightness ❑ Pain on Breathing ❑ Shortness of Breath
Cardiovascular:	❑ Irregular Heartbeat ❑ Rapid Heartbeat ❑ Chest Pain
Gastrointestinal:	❑ Constipation ❑ Diarrhea ❑ Stomach Pain ❑ Black Tarry or Blood in Stools ❑ Nasuea ❑ Vomiting ❑ Indigestion/Heartburn
Musculoskeletal:	❑ Pain in Joints ❑ Back Pain ❑ Swelling of Joints
Endocrine:	❑ Thyroid Disorder ❑ Diabetes ❑ Menopausal Symptoms
Hematological:	❑ Easy Bleeding ❑ Anemia ❑ Swollen Glands/Persistent
Psychiatric:	❑ Depression ❑ Anxiety ❑ Insomnia
Skin:	❑ Rash ❑ Hives ❑ Itching ❑ Eczema ❑ Infections ❑ Dry Skin
Neurological:	❑ Headaches ❑ Weakness ❑ Dizziness ❑ Seizures

Reviewed By: _____ **Date:** _____