

Name: _____ Date of Birth: _____

Referring / Primary Care Doctor: _____

1. What is the reason(s) you are seeing an allergist? _____

How long have you had these problems? _____

Are they getting worse? Y / N. If yes, explain: _____

2. Allergy Symptoms: (circle all symptoms that pertain to you)

Eyes: itching redness watering dryness eyelid swelling pain dark circles under eyes

Ears: popping pressure pain itching drainage hearing loss frequent infections

Nose: sneezing itching runny nose congestion/stuffy nosebleeds mouth breathing

Nasal drainage is: clear white discolored thin thick

Sense of smell is: normal decreased absent (how long?) _____

Throat: itching frequently sore post nasal drip frequent throat clearing hoarseness

Other symptoms: _____

What are your one or two **worst** symptoms? _____

How do you describe your level of symptoms: mild moderate severe

Do symptoms limit daily activities: Y / N. If yes, how so? _____

Are your symptoms (circle one): Seasonal / Year-round / Both seasonal and year-round

Seasonal symptoms occur during the following month(s): (circle all that pertain to you)

Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec

What is(are) the **worst** season(s)? (Circle) Spring / Summer / Fall / Winter / None

Circle **all** factors that aggravate your eye, ear, nose and throat symptoms:

Mown lawn	Outside dust/dirt	Flowers
Raking leaves	Barn dust	Perfume/cologne
Pollen: _____	Hay	Cigarette smoke
Cats	Any weather change	Cleaning products
Dogs	Humid days	Exhaust
Other animals: _____	Damp days	Gasoline fumes
House Dust	Exercise	Aspirin
Feathers	Beer/wine	Ibuprofen
Mold	Spicy hot food	Other triggers: _____

Are symptoms better away from home? Y / N. If yes, where: _____

Have you ever had allergy skin testing before? Y / N. If yes, when and what were the results? _____

Have you ever been on allergy shots? Y / N. If yes, when and for how long (yrs.)? _____

Also, did your symptoms improve? _____

Are you considering starting allergy shots? Y / N / unsure

3. Sinuses/Sinus Infections

Have you ever been treated for a sinus infection? Y / N: ***If no, go to question 4***

If so, how many times in the past year have you been on antibiotics for sinus infection? _____

When were you last treated? _____ If known, name of antibiotic: _____

Usual duration of antibiotic: _____ days. Does the infection resolve with antibiotics? (circle)

Always Usually Often need another course Never seems to go away Unsure

What antibiotics usually work? _____ Any that don't work? _____

Do symptoms improve with prednisone (oral steroids): Y / N. Number of courses in last year: _____

Typical sinus infection symptoms: _____

Have you had a sinus x-ray or CT scan? Y / N. If yes, when was the last one done? _____

Any history of nasal polyps? Y / N. Any prior sinus surgery? Y / N. If yes, when and for that?

4. Sinusitis Symptoms: Any symptoms now (circle all that pertains to you):

Nasal blockage Sinus tenderness Facial pain Tooth pain Sinus headaches Eye/face swelling
Yellow/green nasal drainage Bad tasting/discolored post nasal drip Sore throat Bad breath

5. Asthma and Inhaler Use

Any prior history of asthma or inhaler use? Y / N. *If no, go to question 5*
If asthma, when were you first diagnosed? _____ Any prior hospitalizations for asthma? _____
Number of Emergency Room or Urgent Care visits for breathing difficulty in the past year _____
Number of courses of prednisone (oral steroids) in the past year for asthma symptoms _____
How often in an average week do you need or use your rescue inhaler (albuterol, Proventil, Ventolin,
Maxair) for symptoms during the day? _____ times per week. Do you need it daily? Y / N
Do you use it in the middle of the night? Y / N. How many times at night per month? _____.

6. Respiratory symptoms (circle all symptoms that pertain to you frequently)

Chest symptoms: cough chest tightness shortness of breath wheezing other: _____

If cough, do you bring up mucus/phlegm? Y / N. Color: _____

Does your symptoms prevent you from doing any daily activities? Y / N:

If yes, list activities: _____

Does your breathing symptoms wake you at night? Y / N. What time of night? _____

Increased seasonal symptoms (circle): Spring Summer Fall Winter

Symptom triggers (circle all that pertain to you):

Exercise	Cats	Colds/bronchitis
Cold air	Dogs	Sinus infections
Smoke	Pollen: _____	Aspirin/Ibuprofen
Perfume	Mown lawn	Raking leaves
Mold	House dust	Outdoor dust/dirt

Other triggers: _____

Do you often get a hacking cough after a cold/viral infection that doesn't go away (≥ 2 weeks)? Y / N

Have you had a chest x-ray? Y / N. If yes, when was the last one done? _____

7. Pneumonia

Any prior history of pneumonia? Y / N. If yes, when? _____

Was a chest x-ray done for the diagnosis? _____

8. Skin

Any history of eczema? Y / N. If yes, list locations: _____

Any history of hives? Y / N. If yes, list locations: _____

Any other skin rashes, itching or swelling? Y / N. If yes, list locations: _____

What triggers symptoms: _____

9. Stomach acid reflux (can trigger nose/sinus symptoms and/or asthma)

Any prior history of acid reflux? Y / N. If yes, list medication(s) used and effectiveness _____

Symptoms (circle all that pertain to you):

Heartburn Indigestion Bitter taste in throat Acid backwash into chest
Heartburn at night/lying down Trouble swallowing (food getting stuck)

Above symptoms occur how many times per week: _____

10. Food Allergy

Any prior food allergic reactions? Y / N. If yes, list food(s) and reaction(s) _____

11. Bee Sting / Fire Ant Reactions

Any prior serious reaction to bee sting? Y / N. Fire ant? Y / N. If yes, circle all symptoms:

Large local swelling Hives Swelling of the face / tongue Throat tightness Chest symptoms

Trouble breathing Stomach symptoms Dizziness Fainting Anaphylaxis Other: _____

When did the last reaction occur? _____

12. Current medication(s) and doses: (include all current medications and supplements)

Medication	Dose	Times/day	Effectiveness	Side effects
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

13. Prior medications for asthma or allergies: (do not include current medications)

List any other prior medications for allergies or asthma that you have tried in the past.

Medication	Effectiveness	Side effects
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

14. Medication Allergies: List any medication allergy, date and reaction

Medication	Date	Reaction
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

15. Pregnancy (Women)

Are you currently pregnant? Y / N. Are you trying to get pregnant now? Y / N

Are you currently breastfeeding? Y / N

16. Past Medical History

List any prior surgeries, medical conditions, and/or hospitalizations:

Surgeries: _____

Medical conditions: _____

Hospitalizations (include reason admitted/year): _____

17. Immunizations

Childhood immunization completed: Y / N.

Do you get the flu shot yearly? Y / N. Last flu shot: _____

Reaction to immunizations? _____

18. Family History

Any family history of allergies/hay fever, asthma, eczema, other: (Circle all that pertain)

Mother: allergies/hay fever asthma eczema other: _____

Father: allergies/hay fever asthma eczema other: _____

Siblings: allergies/hay fever asthma eczema other: _____

Children: allergies/hay fever asthma eczema other: _____

Additional comments: _____

19. Social History

How long have you lived in Charlotte or surrounding areas? _____

Live in (circle): house apartment duplex condo other: _____

How long have you lived in current residence? _____ Approximate age of building _____

Cooling system: central air conditioning A/C window unit(s) fresh air/open windows

Heating system: forced air steam (radiator) baseboard other: _____

Do you have: wood/coal stove humidifier dehumidifier air cleanser/filter HEPA vacuum

Bedroom: wall-to-wall carpet area rug hardwood floor basement other: _____

Any mold problem(s)? leaky roof damp basement visible mold standing water

If yes, list problem(s): _____

Any birds or furred pets at home? Y / N. If so, what type and how many _____

Are the pets allowed in your bedroom? Y / N. If yes, do they sleep in the bedroom? Y / N

Do you have symptoms around your pet(s)? Y / N. If yes, describe: _____

Do you use allergy proof encasings? Y / N. If yes: mattress / pillows / both

Any pests at home? Y / N. If so: cockroach / mice. At work? Y / N. If so: cockroach / mice / rat

Do you smoke? Y / N. If yes, packs per day _____ for number of years: _____

If no, did you ever smoke? Y / N. Formerly smoked ___ packs per day for ___ yrs, quit x ___ yrs

Any other smokers at home? Y / N. If yes, who? _____ Do they smoke indoors? Y / N.

Hobbies, activities or sports: _____

Foreign travel (include location and year): _____

20. Occupation

Occupation (write student if in school): _____

Any symptom triggers at work/school? _____

21. Latex

Any latex exposure (gloves, balloons, etc.)? Y / N. If yes, what and where? _____

Any symptoms with latex exposure? (Circle all that pertain)

Rash Itching Hives Sneeze Itchy nose Runny nose Congestion Eye symptoms

Cough Wheeze Chest tightness Shortness of breath Other: _____

SIGNATURE OF PATIENT/ PARENT OR LEGAL GUARDIAN *DATE*

THANK YOU FOR TAKING THE TIME TO THOUGHTFULLY COMPLETE THIS QUESTIONNAIRE! IT WILL HELP FOCUS OUR DISCUSSION AT YOUR INITIAL APPOINTMENT.

Patient Name: _____ Date of Birth: _____

PLEASE CIRCLE OR UNDERLINE SYMPTOMS THAT APPLY TO YOU.

Constitutional Symptoms

Recent weight gain/loss, intentional/unintentional, fever, general weakness, fatigue.

Eyes

Change in vision, glaucoma, cataracts, eye strain, double vision.

Ears, Nose, Mouth and Throat

Ear ringing, vertigo, nasal septal deviation, loss of taste, cavities, gum bleeding, soreness, redness, canker sores/oral ulcers, cold sores, thrush.

Cardiovascular

Chest pain, fast heart rate, slow heart rate, irregular heart rate, palpitations, leg/ankle/foot swelling, leg pain.

Respiratory

Painful breathing, shortness of breath lying down, sleep apnea/episodes of not breathing while sleeping, snoring, change in old cough symptoms, coughing blood.

Gastrointestinal

Increase/decrease appetite, nausea, vomiting, stomach pain, blood in stool, rectal pain and/or bleeding, change in bowel habits, diarrhea, constipation, indigestion, food intolerance, flatus/gas.

Genitourinary

Painful urination, difficulty with urinating, urination at night, urine infections, blood in urine, incontinence, kidney stones. Female – painful menstrual cycles, excessive menstrual bleeding, menopausal symptoms.

Musculoskeletal

Joint pain, stiffness, arthritis, joint swelling, gout, back/neck ache, muscle pain, cramps, soreness, decreased physical activity.

Integumentary

Rashes, redness, flushing, skin eruptions, dryness, cyanosis, jaundice, changes in skin, hair, nails or moles.

Neurological

Dizziness, light-headedness, fainting, blackouts, muscle weakness, seizures, paralysis, tingling, tremors, memory loss, headaches, migraines.

Psychiatric

Personality changes, nervousness, mood changes, insomnia, nightmares, depression.

Endocrine

Heat/cold intolerance, increased sweating, increased thirst, frequent urination.

Hematologic/Lymphatic

Low blood levels/anemia, easy bruising, easy bleeding, blood clots, swollen glands.

Allergic/Immunologic

Frequent infections, food allergy, drug allergy, contact allergy.

Patient Signature: _____ Date: _____