

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

Eyes: itching redness watering dryness

Ears: itching popping pressure pain

Nose: itching sneezing runny nose congestion/stuffy mouth breathing

Nasal drainage is: clear white discolored thin thick

Sense of smell is: normal decreased absent

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

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

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

Skin: eczema/atopic dermatitis hives/welts rash itching swelling

If yes, list locations: _____

Other: _____

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? _____

Do symptoms wake you at night? Y / N. What time of night? _____

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

Circle **all** factors that aggravate your symptoms:

Pollen	Mold	Smoke
Grass/mown lawn	Outdoor dust	Perfume
Raking leaves	Hay	Cleaning products
Cats	Weather change	Exhaust/gasoline fumes
Dogs	Damp days	Aspirin/ibuprofen
House dust	Cold air	Colds/bronchitis
Feathers	Exercise	Sinus infections

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. Infections

Have you ever been treated for sinus or other infections with antibiotics? Y / N: ***If no, go to question 4***

What types of infections were you treated for? _____

How many times in the past year have you been on antibiotics? _____

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

Do symptoms improve with prednisone (oral steroids)? Y / N.

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

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

4. 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 overnight hospitalizations for asthma? Y / N.
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 use your rescue inhaler (albuterol, Proventil, Ventolin, ProAir, Xopenex) for symptoms during the day? _____ times per week.
Do you use it in the middle of the night? Y / N. How many times at night per month? _____.

5. Food Allergy

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

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

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

7. 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
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

8. Medication Allergies (list any medication allergy, date and reaction)

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

9. Past Medical History (please include dates if known)

Medical conditions: _____
Surgeries: _____
Hospitalizations (include reason admitted): _____

10. Family History (please 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: _____

11. Social History

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

Do you have: wood/coal stove humidifier dehumidifier room air filters HEPA vacuum

Bedroom: wall-to-wall carpet area rug hardwood floor feather/down (pillow/blanket)
dust mite encasings (pillow/mattress)

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

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

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: _____

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

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): _____

Occupation (write student if in school): _____

Any symptom triggers at work/school? _____

12. Review of Systems (please circle or underline other symptoms that apply to you)

Constitutional Symptoms: weight gain, weight loss, fever, general weakness, fatigue, night sweats

Eyes: dark circles under eyes, pain, change in vision, glaucoma, cataracts, double vision

Ears, Nose, Mouth and Throat: hearing loss, ear ringing, sinus tenderness, facial pain, nose bleeds, nasal septal deviation, loss of taste, tooth pain, bad breath, canker sores/oral ulcers, thrush

Cardiovascular: chest pain, fast heart rate, slow heart rate, irregular pulse, palpitations, leg/foot swelling

Respiratory: sleep apnea/episodes of not breathing when sleeping, snoring, painful breathing, cough blood

Gastrointestinal: nausea, vomiting, stomach pain, blood in stool, change in bowel habits, diarrhea, constipation, indigestion, heartburn, bitter taste in throat, trouble swallowing, bloating, flatus/gas

Genitourinary: difficulty with urinating, blood in urine, incontinence, kidney stones

Musculoskeletal: joint pain, stiffness, arthritis, joint swelling, gout, muscle pain, cramps, soreness

Skin: redness, flushing, dryness, cyanosis, jaundice, changes in skin, hair, nails or moles

Neurological: dizziness, vertigo, fainting, muscle weakness, tingling, tremors, memory loss, headaches, migraines, seizures, paralysis

Psychiatric: nervousness, depression, mood changes, insomnia, nightmares

Endocrine: heat intolerance, 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/intolerance, drug allergy, contact allergy

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.