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**ALLERGY QUESTIONNAIRE**

Introduction: This questionnaire is designed to help us evaluate your allergic symptoms. Please fill out the questionnaire completely. Basically, it asks what your symptoms are, how long you've had them, how much they bother you and what has been done in the past to treat them. It is also necessary for us to know your past medical history and family history. There is a space for you to add anything else that might be helpful. If you have any questions about how to fill out this questionnaire, feel free to ask any member of our staff for help.

DATE:	
NAME:	
AGE:	
DATE OF BIRTH:	
OCCUPATION (or grade):	
REFERRED BY:	
MR#:	

**Why are you having (or were referred for) an allergy evaluation now and not last year or next?**

**Symptoms**

*(Check)*

Nose

When did nasal symptoms start: 19

- nasal symptoms worsening
- runny ( clear  discolored)
- stuffy
- post nasal drainage
- itchy nose
- sneezing

Chest

When did chest symptoms start: 19

- chest symptoms worsening
- cough
- wheezing
- chest tightness
- sputum

Ears

fullness  popping  itch

Infections

# ear infections a year:   # sinus infections a year:

Other

headaches

Please circle or fill in

Awaken because of allergic symptoms	nightly	2-3x/week	once/weekly	monthly	never
boxes Kleenex per day	few sheets	¼ box	½ box-1 box		
Exercise induced:	cough	wheeze	shortness of breath	chest tightness	
Do symptoms cause	fatigue	anxiety	worry	depression	irritability
Days school missed per year (because of allergic symptoms)		# of nasal symptom free days per week			
Days work missed per year (because of allergic symptoms)		# of wheeze free days per week			
Physician visits for allergy symptoms in past year		Emergency Room visits for allergy symptoms in past year			

Condition is worse when exposed to (check)

- |                                |                                  |                                            |                                 |                                   |
|--------------------------------|----------------------------------|--------------------------------------------|---------------------------------|-----------------------------------|
| <input type="checkbox"/> cats  | <input type="checkbox"/> smoke   | <input type="checkbox"/> Santa Ana winds   | <input type="checkbox"/> spring | <input type="checkbox"/> night    |
| <input type="checkbox"/> dogs  | <input type="checkbox"/> smog    | <input type="checkbox"/> cold air          | <input type="checkbox"/> summer | <input type="checkbox"/> day      |
| <input type="checkbox"/> dust  | <input type="checkbox"/> perfume | <input type="checkbox"/> change in weather | <input type="checkbox"/> fall   | <input type="checkbox"/> indoors  |
| <input type="checkbox"/> grass | <input type="checkbox"/> odors   | <input type="checkbox"/> fog               | <input type="checkbox"/> winter | <input type="checkbox"/> outdoors |
- Other:

Previous Treatment

Allergist	date	Skin Test results	Dates allergy injections given
Ear Nose Throat Surgeon	date	Previous Ear, Nose or Sinus Surgery	effective?
Sinus X-rays or CT scans		Result:	

What medications have you taken in the past for your allergies or asthma

Medication	# times a day	first prescribed	effective?

What medication that you are currently taking (include allergy and non-allergy medications)

Medication	# times a day	first prescribed	for what condition

Other allergic symptoms (check)

- |                  |                                                                                                                                        |
|------------------|----------------------------------------------------------------------------------------------------------------------------------------|
| Skin             | <input type="checkbox"/> hives, <input type="checkbox"/> eczema, <input type="checkbox"/> swelling                                     |
| Gastrointestinal | <input type="checkbox"/> nausea <input type="checkbox"/> vomiting <input type="checkbox"/> diarrhea <input type="checkbox"/> heartburn |
| Respiratory      | <input type="checkbox"/> pneumonia                                                                                                     |

**Drug Reactions**

Drug	Type of reaction	when did it first occur	how often did it occur	How long did reaction last
Aspirin				
Penicillin				
Sulfa				
other:				

**Food Reactions**

Food	Type of reaction	when did it first occur	how often did it occur	How long did reaction last
Milk				
Egg				
Restaurant Meals				
Alcohol				
other:				

**Childhood History (Children only)**

Weeks premature		complications of pregnancy		Birth weight	
Nursed		Formula Changes		newborn jaundice	
diarrhea		vomiting		spitting	
eczema		formula changes		colic	
immunizations up to date		normal development		daycare	

Please list all other illnesses (Past and present)

Illness	Date

**Hospitalizations**

Reason for Hospitalization	Date

If not listed above, please check if you've had the following:

- glaucoma or cataracts   
  high blood pressure   
  heart disease   
  irregular heartbeat  
 hepatitis   
  seizures   
  thyroid   
  prostate problems

smoke \_\_\_\_\_ Packs/day for \_\_\_\_\_ years. Date quit \_\_\_\_\_ Never smoked

*Female:* Reproductive Status

Surgically Sterile

Tubal ligation

Date:

Hysterectomy

Date:

Postmenopausal

Date:

Contraception:

Type

Date:

**Environmental Survey**

How long have you lived in current Residence \_\_\_\_\_ Southern California \_\_\_\_\_

Prior Residences	Dates

What trees are around your house (*list*):

*Please check or complete*

Age of carpeting  years

water damage to carpeting

indoor smoke

plastic covers on mattress

comforter

feather pillow

stuffed animals in bedroom

air purifier

indoor pets (list, how old?)

**Family History (please check)**

Relation	Ages	Nasal Allergy	Asthma	Other allergic problem
Mother				
Father				
Children:				
Siblings				

Please add anything you might think will be helpful in your evaluation: