Steven F. Weinstein, M.D., FAAAAI, FACAAI
Diplomat, American Board of
Allergy and Immunology
Clinical Professor, UCI School of Medicine

ALLERGY QUESTIONNAIRE

Introduction: This questionnaire is designed to help us evaluate your allergic symptoms. Please fill out the questionnaire completely. Basically, it asks what you symptoms are, how long you've had them, 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 space for you to add anything else that may be helpful. If you have 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:

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

____

____

Check the ones that apply:

☐ **Nose**
When did nasal symptoms start: 19____/20____
☐ Nasal symptoms worsening
☐ Post nasal drainage (drip in throat)
☐ Runny (☐clear ☐discolored)
☐ Itchy nose
☐ Stuffy
☐ Sneezing
☐ Mouth Breather
☐ Decreased or no sense of smell
☐ Snores
☐ Nose Bleeds
How often do symptoms occur:
☐ Daily ☐ 2-3 times a week ☐ Weekly ☐ Monthly
☐ Certain seasons

☐ **Eyes**
☐ Itch ☐ Watery/Tearing ☐Red ☐ Puffy/Swollen
☐Dark circles under eyes

☐ **Ears**
☐Fullness ☐ Popping ☐ Itch
Tubes in ears, if so, when______________________________________
_________Number of ear infections in the last year.

☐ **Throat**
☐ Frequent throat clearing ☐ Sore throat ☐ Frequent throat infections
☐Hoarse Voice
☐Tonsil or Adenoid surgery

☐ **Chest** When did chest symptoms start: 19____/20____

☐ Chest symptoms worsening

☐ Cough

☐ Sputum (☐clear ☐discolored)

☐ Wheezing

☐ Chest Tightness

Do you wake up at night due to the symptoms: ☐ Yes ☐ No

How often do symptoms occur:

☐ Daily ☐ 2-3 times a week ☐ Weekly ☐ Monthly

☐ Only when sick with Upper Respiratory Infection

Do Chest symptoms resolve with use of rescue medicine (Albuterol): ☐ Yes ☐ No

Have you done a Pulmonary Function Test or Spirometry in the last 2 years: ☐ Yes ☐ No

Have you been diagnosed with asthma, emphysema, or other breathing problems:
(Circle or write the answer):____

Have you been to the Emergency Room or Hospitalized due to asthma or other breahing problems? ☐ Yes ☐ No If so, please explain____________________________________

____

____

____

☐**Other** ____

____

Check the ones that apply:

Awaken because of allergic Symptoms:	☐ Nightly	☐ 2-3x/week	☐ Once/weekly	☐ Monthly	☐ Never
Boxes of Kleenex per day:	☐ Few sheets	☐ ¼ Box	☐ ½ Box-1 Box	☐ 2 or more boxes	
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 the past year: _________________

Condition is worse when exposed to: (check all that apply)

☐ Cats ☐ Smoke ☐ Santa Ana winds ☐ Spring ☐ Night
☐ Dogs ☐ Smog ☐ Cold air ☐ Summer ☐ Day
☐ Dust ☐ Perfume ☐ Change in weather ☐ Fall ☐ Indoors
☐ Grass ☐ Odors ☐ Fog ☐ Winter ☐ Outdoors
☐ Other: (please specify)______________________________

Do you get Headaches? ☐ yes ☐ no

Describe where you feel the pain:______________________________

Associated Symptoms with headache
☐ Nausea ☐ Vomiting ☐ Sensitivity to light ☐ Sensitivity to sound
☐ Have to lay down in a dark room or sleep to feel better

How often do you have headaches:
☐ Daily ☐ 2-3 time a week ☐ Weekly ☐ Monthly ☐ Change of weather/season ☐ Around menses

How long do they last?______________________

List the medications that you are **taking now** (include allergy and non-allergy medications)

MEDICATION	# TIMES A DAY	FIRST PRESCRIBED	FOR WHAT CONDITION

Previous Treatment:

Have you seen another Allergist? Name:______________________________
Date Seen:____________________
Results of allergy testing (what are you allergic to):______________________________
Did you receive allergy injections (shots): ☐ yes ☐ no
How often do or did you receive allergy injections?______________________________
Any reactions to the injections?______________________________
When was the last injection?______________________________
Did the allergy injections help: ☐ yes ☐ no

Have you seen an Ear Nose Throat Surgeon? Name:______________________________
Date Seen:____________________
Previous Ear, Nose or Sinus Surgery (if applicable):______________________________
Effective: ☐ yes ☐ no

When was your last sinus infection:______________________________
Did the sinus infection resolve: ☐ yes ☐ no
How many sinus infections do you get in a year?______________________________
List the last medication to treat the sinus infection:______________________________
Have you had a sinus X-ray or CT scan of the sinuses within the last year? ☐ yes ☐ no
If so, when/where was it done?______________________________
What were the findings?______________________________

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

MEDICATION	# TIMES A DAY	FIRST PRESCRIBED	EFFECTIVE? (Y/N)

Other allergic symptoms: (check all that apply)

Skin ☐ Hives ☐ Eczema ☐ swelling

Gastrointestinal ☐ Nausea ☐ vomiting ☐ diarrhea ☐ heartburn ☐ acid reflux

Respiratory ☐ Pneumonia

Drug Reactions:

Drug	Type of Reaction	When did it first occur	Was reaction immediate	How long did reaction last
Aspirin				
Penicillin				
Sulfa				
Other:				

Food Reactions:

Food	Type of Reaction	When did it first occur	Was reaction immediate	How long did reaction last	Can you tolerate now
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		Colic		Immunizations up to date	
Normal development		Daycare			

Please list all other illnesses (Past and Present):

ILLNESS	DATE

Hospitalizations:

REASON FOR HOSPITALIZATION	DATE

Female: Reproductive Status

☐ Surgically sterile	☐ Tubal ligation	Date:
	☐ Hysterectomy	Date:
	☐ Postmenopausal	Date:
☐ Contraception	Type	Date:

Environmental Survey:
How long have you live at your current residence_______________ Southern California_______________

Prior Residences	Dates

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

Please check or complete:

☐ 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

REVIEW OF SYSTEMS

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