

Southwest Allergy and Asthma Associates

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Allergy Questionnaire

Date: _____ Referring Doctor: _____ Referring Patient: _____

Last Name: _____ First Name: _____ Birthdate: _____ Male/Female

Phone (Home): _____ Phone (Work): _____ Length of Time in West Texas: _____

MAIN SYMPTOM THAT AFFECTS YOU:

Date that your symptoms began: _____

ALLERGIC SYMPTOMS (check all that apply)

Nasal: Congestion

- Stuffiness
- Clear runny nose
- Discolored mucus
- Sneezing
- Itching
- Rubbing

Sinus: Headache

- Snoring
- Loss of Smell
- Bad Breath
- Sinusitis
- Fever
- Chills
- Bloody nose

Throat:

- Hoarseness
- Postnasal drainage
- Throat clearing
- Sore throat

Eyes:

- Itching
- Watering
- Redness
- Swelling
- Blurry vision

Ears:

- Pain
- Popping
- Infections
- Tubes in ears
When placed _____

Skin:

- Rash
- Itching
- Eczema
- Insect sting reaction

Lungs:

- Dry cough
- Productive cough
- Chronic cough
- Pneumonia
When? _____
- Bronchitis
When? _____
- Bronchiolitis
When? _____
- Past chest X-ray
When? _____

ASTHMA SYMPTOMS:

When diagnosed? _____

Hospitalizations? _____

- Wheezing
- Shortness of breath
- Chest tightness
- Nighttime symptoms
- Symptoms with infections
- Symptoms with exercise
- Symptoms only at work
- Recent albuterol use
- Spacer use
- Missed school or work
- Do you use a peak flow meter? _____ Las

THESE SYMPTOMS OCCUR DURING:

- Spring
- Summer
- Fall
- Winter
- Morning
- Afternoon
- Evening
- Night
- At home
- At work
- Indoors
- Outdoors

SYMPTOMS ARE MADE WORSE BY:

- Colds
- Cutting grass
- Raking Leaves
- Dust
- Cigarette smoke
- Perfume
- Strong Odors
- Detergent
- Airconditioning
- Exercise
- Stress
- Animal exposure

PREVIOUS ALLERGY OR ASTHMA MEDICATIONS:

- | | | | | | | | | | | | | | |
|--------------|--------------------------|------|--------------------------|--------|--------------------------|--------|----------------|--------------------------|------|--------------------------|--------|--------------------------|--------|
| Claritin | <input type="checkbox"/> | Used | <input type="checkbox"/> | Helped | <input type="checkbox"/> | Sleepy | Nasarel | <input type="checkbox"/> | Used | <input type="checkbox"/> | Helped | <input type="checkbox"/> | Sleepy |
| Claritin-D | <input type="checkbox"/> | Used | <input type="checkbox"/> | Helped | <input type="checkbox"/> | Sleepy | Azmacort | <input type="checkbox"/> | Used | <input type="checkbox"/> | Helped | <input type="checkbox"/> | Sleepy |
| Allegra | <input type="checkbox"/> | Used | <input type="checkbox"/> | Helped | <input type="checkbox"/> | Sleepy | Aerobid | <input type="checkbox"/> | Used | <input type="checkbox"/> | Helped | <input type="checkbox"/> | Sleepy |
| Allegra-D | <input type="checkbox"/> | Used | <input type="checkbox"/> | Helped | <input type="checkbox"/> | Sleepy | Flovent | <input type="checkbox"/> | Used | <input type="checkbox"/> | Helped | <input type="checkbox"/> | Sleepy |
| Zyrtec | <input type="checkbox"/> | Used | <input type="checkbox"/> | Helped | <input type="checkbox"/> | Sleepy | Serevent | <input type="checkbox"/> | Used | <input type="checkbox"/> | Helped | <input type="checkbox"/> | Sleepy |
| Zyrtec-D | <input type="checkbox"/> | Used | <input type="checkbox"/> | Helped | <input type="checkbox"/> | Sleepy | Advair | <input type="checkbox"/> | Used | <input type="checkbox"/> | Helped | <input type="checkbox"/> | Sleepy |
| Astelin | <input type="checkbox"/> | Used | <input type="checkbox"/> | Helped | <input type="checkbox"/> | Sleepy | Intal | <input type="checkbox"/> | Used | <input type="checkbox"/> | Helped | <input type="checkbox"/> | Sleepy |
| Hydroxyzine | <input type="checkbox"/> | Used | <input type="checkbox"/> | Helped | <input type="checkbox"/> | Sleepy | Pulmicort | <input type="checkbox"/> | Used | <input type="checkbox"/> | Helped | <input type="checkbox"/> | Sleepy |
| Nasacort AQ | <input type="checkbox"/> | Used | <input type="checkbox"/> | Helped | <input type="checkbox"/> | Sleepy | Singulair | <input type="checkbox"/> | Used | <input type="checkbox"/> | Helped | <input type="checkbox"/> | Sleepy |
| Rhinocort AQ | <input type="checkbox"/> | Used | <input type="checkbox"/> | Helped | <input type="checkbox"/> | Sleepy | Theophylline | <input type="checkbox"/> | Used | <input type="checkbox"/> | Helped | <input type="checkbox"/> | Sleepy |
| Flonase | <input type="checkbox"/> | Used | <input type="checkbox"/> | Helped | <input type="checkbox"/> | Sleepy | Prednisone | <input type="checkbox"/> | Used | <input type="checkbox"/> | Helped | <input type="checkbox"/> | Sleepy |
| Nasonex | <input type="checkbox"/> | Used | <input type="checkbox"/> | Helped | <input type="checkbox"/> | Sleepy | Cortisone shot | <input type="checkbox"/> | Used | <input type="checkbox"/> | Helped | <input type="checkbox"/> | Sleepy |

Do you take Vitamins?

Do you take herbal medications?

PAST ALLERGY HISTORY:

Past allergy testing? Where? _____ When? _____

Prior allergy shots? Where? _____ When? _____

Reactions? _____ Did the shots help?: Completely Moderate Not at all

Nasal surgery? Please describe _____

Broken nose? When? _____

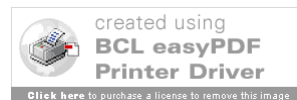
FOOD ALLERGY:

Are there any foods that cause your symptoms? _____

Do any foods cause itching of your mouth? Fresh fruits Fresh vegetables Other _____

DRUG ALLERGIES: _____

DO YOU HAVE THESE IN YOUR HOME:



- Cats
- Dogs
- Birds
- Feather pillow
- Down comforter
- Air cleaner
- Lots of houseplants
- Mold growth
- Secondhand smoke

MEDICAL HISTORY:

Medical problems: _____

Surgeries: _____

Hospitalizations: _____

CURRENT MEDICATIONS: (Continue on back if necessary)

Medication Name:	Dosage	When used?	When Started:	Reason for use
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

FAMILY HISTORY: Allergies Asthma Hives Eczema Sinusitis

Mother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Father	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Son	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Daughter	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Grandfather	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Grandmother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

SOCAL HISTORY:

Do you smoke? _____ How long? _____ When did you quit? _____

What is your occupation? _____

Hobbies? _____

DO YOU HAVE ANY OF THESE SYMPTOMS:

- Arthritis
- Belly pains
- Constipation
- Dark urine
- Dizziness
- Easy bruising
- Fatigue
- Feeling cold all the time
- Fever
- Heartburn
- Jaundice
- Weight loss