

Southwest Allergy and Asthma Associates

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Skin 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: _____

RASH: Are you having? Hives Eczema Dermatitis Skin swelling Rash

Location of your rash? _____

What do you think caused your symptoms? _____

Do you have any of these symptoms with your rash?

- Itching Burning Bruising
 Dark skin color noted after the rash clears
 Shortness of breath Problems swallowing Tongue swelling

Does your skin swell? Where? _____

How long does the rash last?

- A few minutes One hour Several hours Days

New products used:

- Soap Detergent Shampoo Lotion
 Cologne Perfume Indoors Outdoors

New foods eaten since the rash began: _____

Recent use of any of these medications:

- Aspirin Antibiotics Antihistamines Birth control pills
 Herbal products Penicillin Steroids Vitamins

IS YOUR SKIN RASH WORSENER BY ANY OF THE FOLLOWING:

- Heat Cold Water Ex

- Pressure
- Being Outdoors
- Stress
- Insect bites
- Latex gloves
- Vaccinations

IS YOUR SKIN WORSENERED BY EATING OR DRINKING THE FOLLOWING:

- Foods
- Shrimp
- Shellfish
- Fish
- Nuts
- Peanuts
- Citrus fruits
- Diet sodas
- Wine
- Aspirin
- Alcoholic beverages

ARE YOUR SKIN SYMPTOMS WORSE IN THE:

- Morning
- Afternoon
- Evening
- Night

PREVIOUS ALLERGY MEDICATIONS:

Claritin	Used <input type="checkbox"/>	Helped <input type="checkbox"/>
Claritin-D	Used <input type="checkbox"/>	Helped <input type="checkbox"/>
Clarinet	Used <input type="checkbox"/>	Helped <input type="checkbox"/>
Allegra	Used <input type="checkbox"/>	Helped <input type="checkbox"/>
Allegra-D	Used <input type="checkbox"/>	Helped <input type="checkbox"/>
Zyrtec	Used <input type="checkbox"/>	Helped <input type="checkbox"/>
Zyrtec-D	Used <input type="checkbox"/>	Helped <input type="checkbox"/>
Hydroxyzine	Used <input type="checkbox"/>	Helped <input type="checkbox"/>
Atarax	Used <input type="checkbox"/>	Helped <input type="checkbox"/>
Doxepin	Used <input type="checkbox"/>	Helped <input type="checkbox"/>
Elocon cream	Used <input type="checkbox"/>	Helped <input type="checkbox"/>
Diprolene cream	Used <input type="checkbox"/>	Helped <input type="checkbox"/>

Triamcinolone cream	Used <input type="checkbox"/>	Helped <input type="checkbox"/>
Elidel cream	Used <input type="checkbox"/>	Helped <input type="checkbox"/>
Protopic cream	Used <input type="checkbox"/>	Helped <input type="checkbox"/>
Westcort cream	Used <input type="checkbox"/>	Helped <input type="checkbox"/>
Dermatopp	Used <input type="checkbox"/>	Helped <input type="checkbox"/>
Temovate cream	Used <input type="checkbox"/>	Helped <input type="checkbox"/>
Prednisone	Used <input type="checkbox"/>	Helped <input type="checkbox"/>
Cortisone shot	Used <input type="checkbox"/>	Helped <input type="checkbox"/>
Singulair	Used <input type="checkbox"/>	Helped <input type="checkbox"/>

CURRENT MEDICATIONS: (Continue on back if necessary)

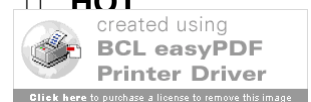
Medication Name:	Dosage	When used?	When started:	Reason for use

DO YOU HAVE? Pets Feather pillows Down comforters

WHAT DETERGENT DO YOU USE? _____ **WHAT SOAP DO YOU USE?** _____

WHAT TEMPERATURE IS YOUR BATH WATER? COLD WARM

OTHER ALLERGY SYMPTOMS:



- Nasal congestion
- Itching
- Bad Breath
- Throat clearing
- Shortness of breath
- Runny nose
- Snoring
- Chronic sinusitis
- Cough
- Chest tightness
- Sneezing
- Headache
- Postnasal drainage
- Wheezing
- Symptoms with exercise

Were you ever skin tested for allergies? _____ When? _____ Where? _____

MEDICAL HISTORY:

Medical problems: _____

Hospitalizations: _____

Past surgeries: _____

DRUG ALLERGIES: _____

FAMILY HISTORY:

	Allergies	Asthma	Eczema	Hives	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"/>
Grandparents	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

SOCAL HISTORY:

Do you smoke tobacco? _____ Have you ever smoked? _____

Do you drink alcohol? _____

What is your occupation? _____ How long? _____

Hobbies? _____

REVIEW OF SYMPTOMS:

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