ALLERGY EVALUATION QUESTIONAIRE Date_____

Patient_____DOB_____Age_____

Please complete the following questions:

Have you ever had severe allergic reaction that required emergency care? YES / NO (if yes explain)

_____
_____
_____
_____

What are the problems that brought you here? And how long have they bothered you?

1._____

_____

2._____

_____

3._____

_____

4._____

_____

Have you ever been diagnosed with asthma? YES/NO

If you have asthma please check the following statements that describe your asthma

_____Asthma symptoms twice a week or more

_____Rescue bronchodilator (albuterol) use twice a week or more

_____Asthma symptoms that occur early in the morning or wake you up at night

_____Asthma symptoms that affect your ability to do exercise, work or school

_____PEF is less than 80% of highest recorded PEF

Would you describe your asthma as well-controlled? YES/NO

What other medical problems are you currently being treated for?

1._____

2._____

3._____

4._____

5._____

What medications are you currently taking? (Please list all in detail)

1._____ 2._____

3._____ 4._____

5._____ 6._____

7._____ 8._____

9._____ 10._____

Please check the following statements that describe your symptoms (check all that apply)

_____Started in childhood
_____Started in adulthood
_____Are similar to other family members
_____Keep you from living a normal life
_____Are controlled by medication

Are you bothered by?

____Grass	____ Barns
____Tree Pollen	____Weather Changes
____Ragweed	____Dusty places
____Wind	____Moldy places
____Dog	____Raking leaves
____Cat	____New buildings
____Horses	____Insect stings
____Perfumes	____smoke
____Pesticides	____medications
____ Cows	____Other_____

History of past allergy treatment:

_____ I am currently on allergy treatment. What clinic? _____

_____ I have had allergy treatment in the past. What clinic? _____

How long ago? _____

____ I have a history of allergies in my family. (explain)

_____

_____

Please list all known allergies:

_____

_____

_____

_____

Symptoms that you have currently or in the past: (circle all that apply)

- Nasal symptoms (runny nose or congestion)
- Ear symptoms (pressure, pain)
- Mouth and/or Throat (post nasal drainage, sore throat, hoarseness, difficulty swallowing)
- Eye symptoms (itchy, increased drainage)
- Headaches
- Breathing problems (shortness of breath, wheezing)
- Cough
    - At night
    - With exercise
- Stomach symptoms (acid reflux, nausea, diarrhea)
- Skin problems (urticaria, eczema)
- Sleep problems (snoring, difficulty falling asleep)

Where do your symptoms bother you the most?

_____Home

_____Work

_____School

Are you regularly exposed to pets or other animals? **YES / NO**

Do you have pets in your home?

What kind of animals? _____

Are you regularly exposed to smoke, perfumes, or other chemicals? **YES / N**