



ALLERGY EVALUATION QUESTIONNAIRE

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?

- | | |
|--------------------------------------|--|
| <input type="checkbox"/> Tree Pollen | <input type="checkbox"/> Barns |
| <input type="checkbox"/> Ragweed | <input type="checkbox"/> Weather Changes |
| <input type="checkbox"/> Wind | <input type="checkbox"/> Dusty places |
| <input type="checkbox"/> Dog | <input type="checkbox"/> Moldy places |
| <input type="checkbox"/> Cat | <input type="checkbox"/> Raking leaves |
| <input type="checkbox"/> Horses | <input type="checkbox"/> New buildings |
| <input type="checkbox"/> Perfumes | <input type="checkbox"/> Insect stings |
| <input type="checkbox"/> Pesticides | <input type="checkbox"/> Smoke |
| <input type="checkbox"/> Cows | <input type="checkbox"/> Medications |
| <input type="checkbox"/> Grass | <input type="checkbox"/> 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 / NO**