Austin Family Allergy & Asthma

Allen K. Lieberman, MD **ALLERGY QUESTIONNAIRE** **Jill Apodaca, FNP-C**

INSTRUCTIONS: Please answer the questions on this form as they relate to the person being evaluated. Please bring the completed forms to our office for your first appointment.

Patient's Name: _____Sex: _____Age: _____Date of Birth_____
Referred by: _____Primary Doctor: _____Appt. Date: _____

I. **BRIEFLY DESCRIBE** the reason for your allergy visit:_____

_____

II. SYMPTOMS: Do you experience any of the following? (Check √ each box that applies to the patient.)

√	NOSE:	√	SINUS:	√	CHEST:	√	SKIN:
	Stuffy nose		Headaches		Tightness		Rash
	Sneezing		Post nasal drainage		Wheezing		Hives
	Itching		Throat clearing / sniffing		Wheezing when exposed to		Eczema
	Clear / colorless discharge		Hoarseness		dust, pollen, animals, etc.		Swelling
	Mouth breathing / snoring		Frequent infections		Wheezing with colds / infections		Itching
	Loss or decreased sense of smell				Wheezing/cough after exercise		
	Nose bleeds				Shortness of breath		
√	EYE:	√	EAR:		Productive cough		
	Red		Itching		Dry cough		
	Itchy		Full / popping				
	Watery		Frequent infections				
	Dark circles / puffiness						

III. TRIGGERS OF YOUR SYMPTOMS: Are your symptoms ☐ Year Round ☐ Seasonal ☐ Both?
During what months do you usually have symptoms? ☐ January ☐ February ☐ March ☐ April ☐ May ☐June ☐ July ☐ August ☐ September ☐ October ☐ November ☐ December

Which of the following cause your symptoms or make them worse? (Check each box that applies.)

	Vacuuming / house dust			Weather change		Chemical fumes
	Mowing lawn / yard work			Molds		Tobacco Smoke
	Cedar			Wet weather		Indoors
	Pollen			Dry weather		Outdoors
	Dogs			Windy day		At home
	Cats			Hot day		At work
	Other animals			Cold day		

Do not write below this line – Continue on to the Next Page

IV. DURATION / SEVERITY OF SYMPTOMS:

Have your symptoms been present: ☐ All of your life? ☐ _____month / years? Are your Symptoms:

	Mild		Rare		Interfering with your life
	Moderate		Frequent		Preventing many normal activities
	Severe		Constant		

V. FOOD REACTIONS: Have you ever had any ***systemic symptoms*** (itching, hives, wheezing, shortness of breath, throat swelling, dizziness, fainting, and shock) after ingestion of food or liquid? ☐ Yes ☐ No If yes, specify:

Do you have chronic ***intestinal symptoms*** (nausea, vomiting, cramps, pain, diarrhea) after ingestion of food or liquid? ☐ Yes ☐ No If yes, specify:

_____

_____

VI. INSECT STING REACTIONS: Have you ever had ***systemic symptoms*** (hives, wheezing, shortness of breath dizziness, fainting) after an insect sting? ☐ Yes ☐ No If yes, specify:

_____

VII. MEDICATIONS: Please list all medications below

Please list all **CURRENT** medications below			Please list **PREVIOUS** ALLERGY and/or ASTHMA medications below
DRUG	**Dose**	**Date Started**	
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			

Have you used nasal sprays? ☐ Yes ☐ No If yes, name:_____

Have you taken cortisone (steroids)? ☐ Yes ☐ No If yes, when:_____

VIII. MEDICATIONS REACTIONS: List any medication allergy or reaction below.

Medication	**Approximate Date**	**Symptoms**

IX. PREVIOUS ALLERGY EVALUATION:

Have you seen an allergist? ☐ Yes ☐ No If yes, allergist's name:_____
Have you had allergy skin testing? ☐Yes ☐No If yes, date: _____any positive reactions☐ Yes ☐ No
Have you received allergy injections? ☐ Yes ☐ No If yes, dates:_____
Did your symptoms improve while you received injections? ☐ Yes ☐ No
Have you ever experienced an adverse reaction to an allergy injections? ☐ Yes ☐ No, If yes, please Specify: _____

X. HOME ENVIRONMENT:

Do you live in a: ☐ House ☐ Apartment ☐ Condo
How long have you lived there? _____Years/Months Age of Home:_____Years
Type of flooring: ☐ Carpet ☐ Wood ☐ Tile ☐ Vinyl ☐ Other
☐ throughout ☐ bedrooms ☐ living room
Do you have any pets? ☐Yes ☐ No If yes, list the number and kind (dog, cat, bird, etc.)
Are your allergy / asthma symptoms worse around your pets? ☐Yes ☐ No
Do your pets live: ☐ Indoors ☐ Outdoors ☐ Both?
Do your pets sleep in your bedroom? ☐Yes ☐ No Do your pets sleep on your bed? ☐Yes ☐ No

XI. WORK ENVIRONMENT:

What is your occupation?_____ Where are you employed?_____
How long have you worked there? _____Is your work environments ☐Carpeted ☐ Tiled ☐Other
Are your symptoms worse at work? ☐Yes ☐ No If yes, please specify:_____
Have you missed time from work because of allergies? ☐Yes ☐ No If yes, how much time?_____

XII. SCHOOL HISTORY / ENVIRONMENT:

Do you attend school? ☐Yes ☐ No If yes, what grade level?_____
Have you missed time from school due to allergies / asthma? ☐Yes ☐ No
If yes, how many days missed last year? _____ Comments: _____

XIII. PAST MEDICAL HISTORY:

Please list any chronic medical conditions/hospitalizations/surgeries below:	**Date**

Childbirth ☐Yes ☐ No If yes, list date / dates

XIV. SYSTEMS REVIEW Please check or circle any that have occurred often over the last few months:
General: Fever, Fatigue, Weight loss / gain, decreased appetite, night sweats
Cardio: high blood pressure, heart disease, chest pain, rapid or irregular heart beats
Gastro: abdominal pain, nausea, vomiting, diarrhea, constipation, heart burn, liver disease
Musculoskeletal: joint pain or swelling, arthritis, autoimmune disease
Skin: rash, itching, dryness, eczema, hives
Endocrine: thyroid disease, diabetes
GU/Renal: frequent urination, kidney disease
Neuro: headaches, attention deficit disorder (ADD), tremor
Psych: Anxiety, depression, stress
Sleep: Insomnia, snoring, apnea, night cough

When was your last chest x-ray _____ CT? _____ Results? _____
Have you had sinus x-rays / CTs? ☐Yes ☐ No If yes, Results?_____

XV. SOCIAL
Where were you born? _____Raised? _____
Where have you lived? _____
_____
When did you move to Central Texas? _____
Are you ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Significant Other
What was the last grade of school you completed? _____
How many children do you have? _____Ages of children? _____
Do you exercise? ☐Yes ☐ No If yes, how often? _____how long? _____
Do you drink alcohol? ☐Yes ☐ No If yes, how often? _____how much? _____

XVI. SMOKING
Do you presently smoke? ☐Yes ☐ No If yes, average number of cigarettes per day: _____
If yes, when did you start? _____
Have you ever smoked? ☐Yes ☐ No If yes, how many years ago? ____When did you stop? _____
Average number of cigarettes you smoke per day when you did smoke? _____
Does anyone smoke in your home? ☐Yes ☐ No If yes, who? _____

XVII. FAMILY HISTORY: (Check each box which applies to a family member.)
List family members who have a history of any of the following illnesses.

	Nose/Eye Allergy		Thyroid Disease
	Asthma		Cancer
	Eczema		Diabetes
	Food allergy		High blood pressure
	Swelling		Heart attack
	Immune deficiency		High Cholesterol
	Autoimmune disease		Kidney disease
	Other		Other