

ALLERGY - IMMUNOLOGY QUESTIONNAIRE



DATE _____ REFERRING PHYSICIAN _____

NAME _____ ph #: (w) _____ (h) _____ (c) _____

DATE OF BIRTH _____ AGE _____ SEX _____

OCCUPATION _____ HOBBIES _____

SPOUSE'S OCCUPATION _____ HOBBIES _____

NUMBER OF YEARS IN AZ _____ OTHER CITIES OF RESIDENCE & YEARS LIVED THERE: _____

If patient is a child: FATHER: Age _____ Occupation _____ Hobbies _____

MOTHER: Age _____ Occupation _____ Hobbies _____

Parents' full names: _____

A. MAJOR REASON FOR REFERRAL: 1) "hayfever" 2) "sinus" 3) asthma 4) ear problems 5) bronchitis 6) eye problems 7) hives 8) eczema 9) drug allergy 10) recurrent infection 11) reaction to insects 12) "stomach" problems 13) other _____

B. In your own words, describe your most distressing symptoms. About how old were you when your problem(s) began and in what way(s) is your life affected?

C. CURRENT MEDICINES FOR ALLERGY OR ASTHMA (Please bring prescription medicines):
List medicine(s) by name, dose or strength of drug, and number of doses taken per day:

	1	2	3	4	5	6
NAME						
DOSE or STRENGTH						
USUAL FREQUENCY PER DAY						
DOES IT HELP?						
SIDE EFFECTS						

D. MEDICINES TRIED BUT INEFFECTIVE: _____

E. OTHER MEDICINES OFTEN USED: _____
(include aspirin, nose sprays, blood-pressure pills, thyroid, etc.)

F. PAST ALLERGY HISTORY (infancy and/or childhood): 1) milk or other food allergy 2) eczema 3) asthma 4) other: _____

G. CHILDHOOD IMMUNIZATIONS: Up-to-date or incomplete? Any unusual reactions? _____

- H. MEDICAL HISTORY: 1) General health: excellent good fair poor (circle one)
2) Weight in the past year: stable gain loss (circle one)
3) Past hospitalizations (give approximate year and reason):

I. OPERATIONS: (circle) tubes in the ears, tonsillectomy and/or adenoidectomy, sinus surgery, removal of nasal polyps, nasal septum repair, chest surgery

J. SYSTEMS REVIEW:

CHECK only those items that apply to your condition and **CIRCLE** the appropriate words following the item. IF ITEM DOES NOT APPLY, LEAVE BOX BLANK.

1. () FREQUENT HEADACHE: Approximate frequency _____
Location of headaches: _____ Relief with: _____
2. () EAR PROBLEMS: mild, moderate, severe, improving, same, worse / itch, drainage, blockage, popping, frequent infections, hearing loss, fluid in ear, ruptured ear drum. _____
3. () EYE PROBLEM: mild, moderate, severe, improving, same, worse / red, itch, tear, swell, pain, discharge, crusting, change in vision. _____
4. () NOSE PROBLEM: mild, moderate, severe, improving, same, worse / sneezing, itching, sniffing, watery mucus, colored mucus, stuffy nose, snoring, sinus infections, nose bleeds, post-nasal drip, polyps, broken nose, loss of smell, nose or sinus surgery, mouth breather. _____
Have sinus x-rays been done? Date: _____ Results: _____
5. () MOUTH AND THROAT: sore throats, frequent clearing, frequent tonsillitis, itchy, hoarseness, cold sores, swollen neck glands, trouble swallowing.
6. () ASTHMA: mild, moderate, severe / improving, same, severe / approximate frequency of wheezing _____
_____ . Attacks/month _____ . Days missed from school or work this past year _____ . Emergency visits this past year _____ . Sleep disturbance: hardly ever, frequent _____ .
7. () HOSPITALIZATIONS FOR ASTHMA: List dates and hospital: _____
_____ .
8. () BRONCHIAL INFECTION AS AN INFANT: bronchiolitis, croup, bronchitis
9. () PNEUMONIA: List dates and hospital: _____ .
10. () ABNORMAL CHEST X-RAYS: Dates: _____ .
11. () CHOKING SPELLS (especially young children): _____ .
12. () FREQUENT CHOKING and/or VOMITING: _____ .
13. () POSITIVE SKIN TEST FOR TB or VALLEY FEVER _____ .
14. () CHRONIC COUGH (not throat clearing): daily, more than 3 months per year, color of mucus if present _____ .
Worse during day or night? _____
15. () CHEST PAIN: _____ .
16. () SMOKING HABIT: past, present. Type _____ . No./Day _____ . How Long _____ .
If you smoked and quit, when did you quit? _____ . Are (were) parents smokers? _____ .
17. () STOMACH OR INTESTINAL PROBLEMS: poor appetite, nausea, vomiting, diarrhea, ulcers, pain, black or bloody bowel movements, heartburn _____ .
18. () ECZEMA, HIVES OR SWELLING: Aggravating factors: _____ .
19. () OTHER SKIN PROBLEM(S): dry, small-bumpy rash, itchy rash, easy bruising
20. () FOOD ALLERGY: List food and reaction _____

_____ .
21. () DRUG ALLERGY: aspirin, penicillin, sulfa, x-ray dyes, local anesthetic, other (describe reaction and date) _____
22. () INSECT ALLERGY: Type of insect _____ . Reaction _____ . Yr. _____ .

NAME: _____

K. AGGRAVATING FACTORS: **CIRCLE** those factors that aggravate allergy symptoms and **CHECK** if made worse by that factor.
If item is not a factor leave blank.

	HAYFEVER	SINUS	EYES	ASTHMA OR BRONCHITIS	HIVES	ECZEMA	OTHER (specify)
SAME ALL YEAR							
JANUARY							
FEBRUARY							
MARCH							
APRIL							
MAY							
JUNE							
JULY							
AUGUST							
SEPTEMBER							
OCTOBER							
NOVEMBER							
DECEMBER							
MORNING							
AFTERNOON							
EVENING							
NIGHT							
COLD AIR							
HEAT							
WIND							
TEMPERATURE CHANGES							
RAIN/FOG							
SMOG							
HOUSE DUST							
MOWED GRASS							
YARD/PARK							
WEEDS							
TREES							
ANIMALS							
TOBACCO SMOKE							
COSMETIC ODORS							
AIR CONDITIONER							
WORSE AT HOME							
WORSE AT WORK/SCHOOL							
WORSE AT BEACH							
WORSE AT TRIPS							
FATIGUE							
RUNNING							
LAUGHTER							
TENSION/EXCITEMENT							
COLDS/VIRAL ILLNESS							
ALCOHOLIC BEVERAGES							
ANTIHISTAMINES							
PREGNANCY							
MENSTRUAL PERIODS							

L. Beneficial factors: Do any of the following factors improve your allergy condition? Record the number(s) of the factor on the line to the right of your symptom.

Condition:

Hayfever _____
 Asthma, wheezing, bronchitis _____
 Hives, eczema _____
 Other: _____

Factor:

1. Trips to mountains
2. Trips to desert
3. Trips to beach
4. When away from home
5. When away from work
6. Air conditioning
7. Exercise (general)
8. Swimming

- M. **CIRCLE** OTHER MEDICAL PROBLEMS: 1) High Blood Pressure, 2) Heart Disease, 3) Angina, 4) Diabetes, 5) Anemia, 6) Transfusions, 7) Tuberculosis, 8) Jaundice, 9) Liver Disease, 10) Arthritis, 11) Bladder or Kidney Infections, 12) Other Kidney Disease, 13) Kidney Stones, 14) Gall Stones, 15) Cancer, 16) Fainting Spells, 17) Convulsions or Epilepsy, 18) Frequent Depression, 19) Irritable, 20) Fatigue, 21) Sleep Difficulty, 22) Prostate Trouble, 23) Thyroid Trouble, 24) Glaucoma.
- N. FAMILY HISTORY: Did anyone in your family ever have any of the numbered conditions? Indicate number(s) on the line to the right of the appropriate blood relation. Number of: Brothers _____ Sisters _____
- | | | |
|--|----------------------|------------------------------------|
| Patient's mother _____ | 1. Hayfever | 8. Insect allergy |
| Patient's father _____ | 2. "Sinus" | 9. Emphysema |
| Patient's brothers _____ | 3. Asthma | 10. Tuberculosis |
| Patient's sisters _____ | 4. Hives or swelling | 11. Diabetes |
| Patient's maternal grandparents _____ | 5. Eczema | 12. Serious infection |
| Patient's maternal aunts or uncles _____ | 6. Food allergy | 13. Death in first 2 years of life |
| Patient's paternal grandparents _____ | 7. Drug allergy | 14. None of the above |
| Patient's paternal aunts or uncles _____ | | |
- O. ENVIRONMENT: 1) House, Apartment, Condo, Mobilehome (**circle**). 2) No. of years living there _____
- 3) How old _____ . 4) Basement, 5) Crawl space, 6) Mildew, 7) Water damage inside, 8) If patient is child, where is most of the day spent? _____
- 9) **Circle** any of the following animals at home and fill in how long you have had them.
Please indicate if the animal(s) are in and/or out of the house.
- | | |
|------------------|---------------------|
| cat _____ | hamsters _____ |
| dog _____ | mice/rats _____ |
| rabbit _____ | birds (type) _____ |
| horse _____ | pigeons _____ |
| guinea pig _____ | others (list) _____ |
- List animals previously in the home you now live in? _____ unknown _____
- List other animals that patient is exposed to regularly: _____
- 10) Does anyone smoke at home? _____ 11) If child, is bedroom shared? _____
- 12) In BEDROOM does patient have: (**circle**)
- HEPA filter, ionizer, electrostatic filter, HEPA vacuum
 - Stuffed toys, stuffed furniture, potted plants, pets sleeping in bedroom
 - Forced air heating . . . How often is filter changed? _____
 - Window air conditioning, evaporative cooler, central air conditioning, air purifier, vaporizer.
 - Wall-to-wall carpet, area rug, or type of flooring _____
 - Curtains, drapes, shutters, blinds, bookshelf, list other furniture in bedroom _____
 - Approximate number of books in bedroom _____ Down comforter, down sleeping bag, wool blankets _____
 - Pillows: dacron, feather, kapok, foam rubber, polyester _____
 - Boxspring and mattress, bunk beds, foam mattress, waterbed, plastic covered mattress, air bed, or crib _____
- 13) NEIGHBORHOOD: (**circle**) factories, dairies, barns, stables, near freeway, empty lots _____
- 14) What trees/grasses are in your neighborhood? _____
- 15) Work exposure: chemical fumes, large amounts of dust, mold or mildew, smokers _____
- 16) Any significant past exposure to chemical fumes: _____ None _____ Yes _____
If yes, explain _____
- 17) **Circle** if you have a gas stove, gas furnace, or kerosene space heater.
- P. ALLERGY TREATMENT:
- Never tested before. If tested before, **CIRCLE** appropriate items: negative tests: (blood or skin)
Positive to: grasses, weeds, trees, dust, animals, mold, foods.
 - Allergy shots: _____ No _____ Yes _____
If yes, Dr.'s name: _____
Dates: From _____ to _____ How often _____
Did it help? none, some improvement, much improvement
Serious reactions to testing or treatment: _____ Yes _____ No _____
 - Has patient ever received Cortisone-like drugs (Prednisone, decadron, steroids) ____ Yes ____ No Date(s): _____
What dose? _____ How long? _____
 - Is there currently an Allergist taking care of a family member? If so, Dr. _____