



Department of Otolaryngology / Head and Neck Surgery
Division of Allergy and Environmental Disease

ALLERGY HISTORY QUESTIONNAIRE

Name: _____ Date: _____

Occupation: _____

Have you ever been tested for allergies? Yes No If yes, please answer the following:

By whom? (Include address, if possible) _____

Were you found to be allergic? Yes No

To what? _____

Were you treated with allergy shots? Yes No

For how long? _____

Did the treatment help? Yes No

Section One – Symptoms

What are the main symptoms that brought you to the doctor? _____

How long have these symptoms lasted? _____

Did anything initiate the symptoms? _____

Does anything make the symptoms better or worse? _____

Are your symptoms worse in: Spring Summer Winter Fall

Please check the conditions below which apply to your symptoms:

A. Symptoms of Pollen Allergy

- Worse outdoors
- Worse on windy days
- Worse on sunny days
- Itching eyes
- Worse outdoors 7:00 to 11:00 am
- Better indoors
- Improved in air conditioning

B. Symptoms of Dust Allergy

- Worse indoors
- Improved outdoors
- Increased after going to bed or at night
- Recur or increase each year with the return of cold weather
- Nasal symptoms with little or no itching of the eyes
- Worse with air conditioning
- Increased in dust (such as in dusting or sweeping)
- Increased on exposure to cold air

C. Symptoms of Mold Allergy

- Worse outdoors between 4:30 and 8:30 pm
- Increased by cool evening air
- Worse while mowing or playing on grass
- Worse from mid-July to November
- Worse at damp or low places
- Distinctly aggravated in fall, winter
- Worse in coastal areas
- Worse on rainy days

D. Symptoms from Specific Contacts

- Worse in house after lights have been on an hour
- Worse in certain rooms: Which ones? _____
- Worse in basement
- Worse around feed mills or barn
- React in a home with cats
- React in a home with dogs
- Worse in your house, but not in others
- Increased by drinking water

Please check any symptoms you are experiencing:

A. Respiratory

1. General

- Pain
- Nose bleeds
- Loss of weight
- Night Sweats
- Temperature elevation
- Tonsillitis
- Frequent colds
- Fatigue
- Difficulty sleeping

2. Nasal Symptoms

- Runny nose
- Itching
- Congestion
 - Intermittent
 - Constant
 - Daytime
 - Nighttime
 - After meals
 - With temperature change
 - Seasonal: Which ones? _____
 - Year-round

3. Cough

- Seasonal
- Year-round
- Particular time of day
 - _____am
 - _____pm
- Worse after colds
- Productive
 - Color _____
 - Consistency _____

4. Sneezing

- Seasonal
- Year-round
- Upon waking up
- At meals
- After meals
- In dust
- In smoke

5. Breathing

- Noisy
- Wheezing
 - Daytime only
 - Nighttime only
 - Anytime
 - With exercise only

6. Voice

- Hoarse
 - Intermittent
 - Constant
 - Worse as day progresses
- Frequent laryngitis

B. Gastrointestinal

1. Mouth

- Sore lips
- Sore mouth
- Sore tongue
- Roof itches
- Lip swelling

2. Stomach

- Retasting food
- Nausea
- Vomiting
- Cramps
- Bloating

3. Throat

- Sore
- Scratchy
- Lump in throat
- Difficulty swallowing

4. Rectal

- Itching
- Pain

1. Shortness of Breath

- Daytime
- Nighttime
- With exercise
- # of Pillows for sleep? _____

1. Headaches

- Age at onset _____
- Duration _____
- Frequency
 - Regular
 - Irregular
 - At menses only
- Migraine

3. Fatigue

- Upon waking up
- After meals
- Without exercise
- Constant

E. Musculoskeletal

1. Aching Muscles

2. Joint Pain

- Continuous
- Intermittent
- After meals
- Seasonal

3. Arthritis

4. Bursitis

H. General

- Pain
- Night sweats
- Frequent colds
- Difficulty sleeping

5. Appetite

- Good
- Selective
- Poor

C. Cardiovascular

2. Swelling

- Face
- Hands
- Legs
- Time of day? _____

D. Neurological

2. Ears

- Tinnitus or ear ringing
- Vertigo or dizziness
 - Seasonal: Which ones? _____
 - Year-round
 - After eating: What foods? _____
 - With weather change
 - On windy days
 - On overcast days
- Frequent infections
- Fluid behind eardrums
- Drainage

F. Genitourinary

1. Urination

- Painful
- Delayed
- Prolonged
- Frequent
 - Daytime
 - Nighttime
- Bed Wetting

- Nose bleeds
- Temperature elevation
- Fatigue
- Watery eyes

3. High Blood Pressure

4. Chest Pain

5. Heart or Pulse Irregular

6. Previous Heart Disease

Meniere's disease

Hearing fluctuation

Seasonal: Which ones? _____

Year-round

After eating: What foods? _____

With weather change

On windy days

On overcast days

Hearing loss: Which ears? _____

Ear fullness or pressure

Problems changing altitude

G. Skin

1. Rash

Duration _____

Location

Generalized (all over)

Localized: Where? _____

2. Eczema (dry, scaly skin)

3. Fungal Infection (nails, skin)

Loss of weight

Tonsillitis

Fatigue

Itchy eyes

Section Two – Environmental Exposures

A. Home

1. Type

- Single house
- Duplex
- Apartment: Floor? _____
- Hotel
- Trailer

2. Details

- Slab foundation
- Crawl Space
- Basement
- Papered walls
- Sheet rock
- Garage: Attached? _____

3. Region

- City, industrial
- City, residential
- Suburban
- Small town
- Rural

4. Heating and Ventilation

- Central Heat
 - Gas
 - Electric
- Central Air

5. Washer and Dryer

- Washer: Location? _____
- Dryer: Location? _____
 - Gas
 - Electric

6. Other

- Indoor plants: Location? _____
 - Types? _____
- Fireplace
 - Wood
 - Gas
- Feather or down pillows / comforter

B. Chemicals in Home Use (Indicate Brand Name)

- Roach chemical

- Household cleaners

- Exterminator service

- Ant chemical

- Air fresheners

- Others

- Chlorine cleansers

- Aerosols

C. Animals and Birds (Indicate Type)

- Dog

- Gerbil, hamster, mouse, etc.

- Cat

- Horse

- Birds

- Other

D. Food

- Vegetarian
- Eat organic only
- On a diet: Type? _____
- Food cravings (describe) _____
- Food sensitivities or reactions (list food and type of reaction) _____

D. Work

Describe your work location: _____

- Symptoms worse at work
- Symptoms improved at work
- Foul odors or chemicals at work (describe) _____

D. Check Any of the Following That Aggravate Your Symptoms

- Paint fumes
- Smoke
- Cooking odors
- Newspapers
- Road dust
- Air pollution
- Wool
- Gasoline
- Other _____

Section Three – Family History

Please indicate if any of your family members have had any of the following health problems:

	Father	Mother	Brother	Sister	Child
Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hives	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eczema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Food Allergies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sinus Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Section Four – General Medical History

Please check any of the following medical conditions you are experiencing, or have experienced in the past:

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Heart attack | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Sinus disease | <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Nasal polyps | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Stomach or intestinal disease |
| <input type="checkbox"/> Thyroid dysfunction | <input type="checkbox"/> Seizures | <input type="checkbox"/> Headaches | <input type="checkbox"/> Migraines |
| <input type="checkbox"/> Hives | <input type="checkbox"/> Skin disease | <input type="checkbox"/> Food allergies | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Chronic fatigue | <input type="checkbox"/> Diabetes | |

Please list all current prescription medications and dosages: _____

Please list all current supplements (vitamins, minerals, etc.) and herbs: _____

Have you ever had a bad reaction to a medication? Yes No If yes, please list the medication and reaction:

Do you smoke? Yes No If yes, what do you smoke and how much? _____

Do you drink alcohol? Yes No If yes, what type and how much? _____

Stopped smoking in _____ Stopped drinking in _____

Please check this box if there are any other issues you would like to discuss with the doctor, but do not feel comfortable reporting on this questionnaire.

Thank You!