

Allergy & Asthma Center of Fairfax

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Diplomats of
American Board of Pediatrics
American Board of Internal Medicine
American Board of Allergy & Immunology

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Allergy Questionnaire

Date: _____

Please print out this questionnaire and complete it and remember to bring it with you for your first visit. The purpose of this questionnaire is to obtain the most complete and accurate history of your allergy problems. Many of the questions may not deal directly with your specific allergies, but please answer all the questions which pertain to you and your general health. Freely refer to any medical or environmental records you have including labels on pillows and mattresses, baby books, check books and other records you have at home. Please also have your other doctors send to you reports of any related x-rays or laboratory tests, although do not delay the appointment with us until all the records are in.

Please do not take any anti-histamines for 5-7 days before your visit for allergy testing. This includes such medications as Benadryl, Chlortimeton, Claritin, Clarinex, Zyrtec, Allegra, Atarax(Hydroxyzine) and some other prescription and over-the-counter cold and cough medications. Please ask us if any of your medications contain an anti-histamine. You do not need to stop your asthma medications, inhalers, nasal sprays, heart, blood pressure, thyroid or most other medications. Please call us if you feel you cannot stay off anti-histamines for 5-7 days so we can make other arrangements.

Name: _____

Sex: M _____ F _____

Address: _____

Date of Birth: _____

Preferred Contact: Home Phone: _____

Cell Phone: _____

Work Phone: _____

Name of the consulting physician: (please fill out info below if you have a consulting physician in order for us to send a letter to him or her about our assessment)

Name: _____

Fax: _____

Address: _____

Phone: _____

Chief Complaint

What is the main reason for your visit to our Allergy and Immunology clinic? How long have you had this problem?

Please list the approximate dates and findings of any previous allergy testing and evaluation:

If you have received allergy injections in the past, please list the years you received them:

Patient Name:

DOB:

Chart No.:

Past Medical History

Birth Weight and Gestational Age (40weeks is full term) _____

Have you had the following diseases or conditions? (If yes, when did it start?)

	Yes	No	
Illness at birth	___	___	_____
Childhood Illnesses:			
Chicken Pox	___	___	_____
Whooping Cough	___	___	_____
Croup	___	___	_____
High Blood Pressure	___	___	_____
Cataracts or glaucoma	___	___	_____
Thyroid disease	___	___	_____
Heart Disease or arrhythmia	___	___	_____
Heartburn or reflux	___	___	_____
Osteoporosis	___	___	_____
Liver disease	___	___	_____
Kidney disease	___	___	_____
Other medical problems			_____

Infection History

Circle if yes: blood infection, bronchitis, chickenpox (or varicella vaccine), hepatitis, HIV, otitis (ear infections), meningitis, pneumonia, sexually transmitted disease, shingles (zoster), sinusitis, urinary infection, other:

Previous Hospitalizations/Surgeries/ER visits

(Year)

(Procedure or Reason for hospital or ER visit)

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Drugs Allergy: (Please describe briefly any known allergies to drugs in appropriate spaces.
If unknown, check appropriate box)

- Penicillin: _____
- Sulfa drugs: _____
- Aspirin, Motrin, Advil, etc (NSAIDS) : _____
- Other: _____
- Unknown: (I am unaware of any drug allergies)

Allergy History

Foods:	Yes	No	Reaction or Symptoms:
Nuts	—	—	_____
Peanuts	—	—	_____
Fish	—	—	_____
Shellfish	—	—	_____
Milk	—	—	_____
Egg	—	—	_____
Wheat	—	—	_____
Soy	—	—	_____
Melon	—	—	_____
Banana	—	—	_____
Other: _____	—	—	_____

Animals:	Yes	No	Reaction or Symptoms:
Cats	—	—	_____
Dogs	—	—	_____
Horses	—	—	_____
Insect stings, bites	—	—	_____
Other: _____	—	—	_____

Patient Name:	DOB:	Chart No.:
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Allergy History (Continued)

Other Substances	Yes	No	Reaction or Symptoms:
Latex	___	___	_____
Nickel, other metal: _____	___	___	_____
Poison Ivy	___	___	_____
Radiocontrast (IVP) dye	___	___	_____
Other: _____	___	___	_____

Review of Symptoms

		Yes	No
Constitutional	Have you experienced weight loss?	___	___
	Do you have recurrent unexplained fevers and chills?	___	___
	Do you have night sweats?	___	___
Eyes	Do you have watery or itchy eyes?	___	___
	Do you have burning, redness or discharge?	___	___
ENMT	Do you have ear pain or pressure?	___	___
	Do you have sinus pain or pressure?	___	___
	Do you have loss of smell?	___	___
	Do you have lip swelling or tongue swelling?	___	___
	Do you have soar throat?	___	___
Heart	Do you have skipped beats or palpitations?	___	___
	Do you have chest pain or tightness?	___	___
	Do you have any loss of consciousness or black-outs?	___	___
Respiratory	Do you have a persistent cough?	___	___
	Do you get short of breath easily or wheeze?	___	___
	Have you ever coughed up blood?	___	___
	Do you have shortness of breath?	___	___
	<ul style="list-style-type: none"> • At rest? • With exercise? • When asleep? 	___	___
Gastrointestinal	Do you have heartburn or reflux?	___	___
	Do you have any blood on stools or black tarry stools?	___	___
	Do you have abdominal pain?	___	___
	Do you have vomiting or diarrhea?	___	___
Genitourinary	Do you have painful or unusually frequent urinations?	___	___
	Do you have any blood in urine?	___	___
Musculoskeletal	Do you have any pain or swelling in your joints?	___	___
	Do you have any back pain or muscle aches?	___	___
Skin	Do you have any skin rashes?	___	___
	Do you have any swelling or hives?	___	___
	Do you have any itching?	___	___
	Do you have any dryness or cracking?	___	___

Patient Name:	DOB:	Chart No.:
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Review of Symptoms (Continued)

Yes No

Neurologic	Do you have migraines or headaches?	___	___
	Do you have any dizziness or ringing in ears?	___	___
	Do you have any visual changes?	___	___
Psychiatric	Are you bothered by depression or anxiety?	___	___
Endocrine	Have you become unusually thirsty recently?	___	___
	Do you sense room temperature differently from others?	___	___
Hematologic/Lymphatic	Do you tend to bruise or bleed easily?	___	___
	Do you feel weak and tired easily?	___	___
	Do you have any swollen lymph nodes?	___	___
Immunologic	Do you get frequent infections requiring antibiotics?	___	___

Patient Signature:

Date:

(Please Stop Here)

Allergy Questionnaire Reviewed by: _____ **MD**

Date: _____

Patient Name:

DOB:

Chart No.: