Allergy Questionnaire - Intake Questions

To Be Filled Out by Patient

Patient Name _____ Birthdate _____

Reviewed by _____ Date _____

1. Do you experience any of these symptoms more than twice per year? (Check all that apply)
   - ❑ Cough
   - ❑ Cold
   - ❑ Congestion
   - ❑ Difficulty breathing
   - ❑ Headaches
   - ❑ Wheezing
   - ❑ Runny nose
   - ❑ Sore throat
   - ❑ Itchy/irritated eyes
   - ❑ Sinus pain
   - ❑ Ear pain
   - ❑ Unexplained fatigue
   - ❑ Skin irritation
   - ❑ Snoring

2. Have you ever been diagnosed with asthma or bronchitis? ❑ Yes ❑ No

3. Do you experience symptoms of allergies? ❑ Yes ❑ No

4. Regarding possible food allergies, do you experience any of the following? (Check all that apply)
   - ❑ Bloating after eating
   - ❑ Diarrhea
   - ❑ Cough
   - ❑ Constipation
   - ❑ Upset stomach
   - ❑ Wheezing
   - ❑ Stomach pain
   - ❑ Indigestion
   - ❑ Nausea
   - ❑ Vomiting
   - ❑ Tingling of the mouth or any other unusual sensation

Allergy Questionnaire - Part 2

To be filled out with allergy counselor after initial screening

1. What symptoms are you experiencing? (From #1 on intake form) _____

2. How often do you experience these symptoms? _____

3. Do you have any of these symptoms?

❑ Cough	❑ Runny Nose	❑ Nasal Polyps	❑ Eczema
❑ Wheezing	❑ Nasal Congestion	❑ Poor Sense of Smell	❑ Hives / Swelling
❑ Shortness of breath	❑ Itchy Nose	❑ Ear Infections	❑ Headaches
❑ Chest tightness	❑ Itchy / Watery Eyes	❑ Sinus Infections	❑ Snoring
❑ Sneezing	❑ Postnasal Drip	❑ Blocked Ears	❑ Fatigue
❑ Phlegm/sputum (Color_____)		❑ Other_____	

4. Which of the following seems to bother you or trigger/cause the above symptoms?

❑ Grass	❑ Cats	❑ Cosmetics	❑ Drafts
❑ Nervousness	❑ Hay	❑ Dogs	❑ Aerosol sprays
❑ House Dust	❑ Cold Air	❑ Mold & Mildew	❑ Horses
❑ Perfumes	❑ Smoke	❑ Humidity	❑ Basements
❑ Other Animals	❑ Insecticides	❑ Pollution	❑ Weather changes
❑ Leaves	❑ Alcoholic beverages	❑ Odors	❑ Exercise
❑ Latex (rubber)	❑ Insect bites/stings. Describe reaction: _____		

❑ Foods. List foods and reactions: _____

❑ Other. List sources and reaction: _____

5. When are your symptoms worst?
❑ Year Round ❑ Jan. ❑ Feb. ❑ Mar. ❑ Apr. ❑ May ❑ Jun. ❑ Jul. ❑ Aug. ❑ Sep. ❑ Oct ❑ Nov. ❑ Dec.

6. Are symptoms better away from home? ❑ Yes ❑ No If yes, when? _____

7. Do you have any family history of allergies? Explain _____

8. Have you ever had an allergy skin test or blood test? ❑ Yes ❑ No If yes, results: _____

9. Have you ever had allergy injections? ❑ Yes ❑ No If yes, when? _____

10. Have you received cortisone (prednisone, methylprednisolone, etc.) drugs? ❑ Yes ❑ No
If yes, when? _____ How much? _____

11. Are you on allergy medications? ❑ Yes ❑ No If yes please list meds, dosing and frequency _____

12. What is your occupation? (current or former) _____

OFFICE USE ONLY

Is patient...

- Suffering from uncontrolled asthma
- History of anaphylaxis

IF YES TO ABOVE, REFER OUT TO SPECIALIST

- Required to take beta blockers within 24 hours of test
- Pregnant
- Heavily tattooed
- Significantly immunocompromised or have malignancy or severe chronic illness?

IF YES TO ABOVE, SELECT BLOOD TEST

- Currently taking antihistamine (must be off for 72 hours)
- Wheezing or having difficulty breathing?
- Experiencing active hives, sunburn or extensive dermatitis?

IF YES TO ABOVE, TREAT SYMPTOMS AND SCHEDULE FOR ANOTHER DAY

- Having symptoms consistent with food allergies?

IF YES TO ABOVE, CONSIDER SKIN PANEL AND FOOD PANEL

Indications: Inhalant Panels: ❑ Skin Test ❑ Blood Test **Food Panels:** ❑ Skin Test ❑ Blood Test

Schedule skin test for (date): _____

Patient Name Birthdate Reviewed by Date