

ALVERNON ALLERGY & ASTHMA, PC

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ADULT ALLERGY QUESTIONNAIRE

Name: _____ Age: _____ Date: _____

Primary Care Physician: _____ Referred by Dr.: _____

Also Notify Dr.: _____

1. Describe what brings you to our office: _____

2. Please **circle** the allergy related problems, which bring you to our office today.

NOSE	EYES	EARS	MOUTH/THROAT	CHEST	SKIN
sneezing	itching	itching	sore	cough	itching
itching	burning	fullness	itching	shortness of breath	hives
stiffness	swelling	popping	swelling	wheezing	rash
mouth breathing	bloodshot	hearing loss	post-nasal drip	sputum	eczema

3. How long have you had the symptoms related to this visit? _____

4. Symptoms or problems are: () same all year round () worse in circled months:

Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun

5. Please **circle** what makes the symptoms worse:

Stress	Exercise	Infections (cold, etc.)	Wind
Heat	Dampness	Cool Temperatures	Sunlight
Heaters	Air Conditioning	Evaporative Coolers	Weather Changes

6. Specific Exposures: (Please **circle** the exposures, which will make the symptoms worse)

House dust	Outdoor dust	Mowing lawn
Musty places	Pets or other animals	Barns or stables
Food preparation	Gardening	Chemicals
Smoke	Perfumes	Paint
Cosmetics	Other _____	

7. Are there any foods you avoid or suspect cause your symptoms? (**Circle** if Yes)

Eggs	Peanuts	Milk	Nuts	Wheat
Fish	Shellfish	Fruit	Other: _____	

8. How long have you lived in Southern Arizona? _____ years/months

Have you had allergy tests?	() Yes	() No	If yes, when? _____	Where? _____
Were they skin tests?	() Yes	() No	Or other type? _____	
Had allergy shots in the past?	() Yes	() No	How long ago? _____ years	
Did they help your symptoms?	() Yes	() No	Why were they stopped? _____	

9. Have you ever had a reaction to an insect sting or bite? () Yes () No

If yes, when? _____ Type of reaction: _____
Treatment: _____

10. Treatment:

Prescription or "over the counter" medications you are **presently taking for allergies, asthma, hives, or eczema, including those stopped** in preparation of this visit: (inhalers, drops, tablets, etc.)

Medications Taken	Is the Medication Effective?	Side Effects:
1) _____	_____	_____
2) _____	_____	_____
3) _____	_____	_____
4) _____	_____	_____

Prescription or "over the counter" medications **tried in the past for allergies, asthma, hives or eczema**

Please continue on the other side →

Medications currently taken for **other medical conditions** (include herbal or health store products):

- 1) _____ 3) _____ 5) _____
- 2) _____ 4) _____ 6) _____

11. Reactions to medications. Please list all medications, prescribed or "over the counter", which have caused adverse reactions:

12. Please list any other medical conditions:

- 1) _____ 2) _____ 3) _____

Hospitalizations or Operations: () No () Yes, when and what for: _____

13. Family History: Is there allergic rhinitis, asthma or eczema in any family members?:

Brothers or sisters (please list) _____

Parents (please list) _____

Grandparents (please list) _____

Are there any other medical issues that run in the family? _____

14. Your Occupation: _____ **Spouse's Occupation:** _____

Hobbies: _____

15. Environment and exposures (please circle):

- Type of Home: House Apartment Manufactured Home
- Age of Home: less than 5 years 5 - 15 years over 15 years old
- Heating System: Gas Electric Heat Pump Space Heaters
- Cooling System: Evaporative Cooler Air Conditioning Fans only
- Fireplace: yes but not used no
- Stove: Gas Electric
- Number of inside pets: Cats _____ Dogs _____ Birds _____ Other _____
- Sleeping place of the pets: _____ Outside pets: _____
- House plants: less than 20 more than 20

Is **your bedroom** carpeted? Yes No

Type of mattress: Regular inner spring Foam Waterbed Dust covers

Type of pillows: Feather or Down Foam Synthetic Dust covers

Bedding: Comforters Quilts Wool Blankets Other _____

Landscape: Desert Non-desert

Grass: Type _____

Trees: Mulberry Olive Mesquite Cottonwood Palo Verde Other _____

Weeds: Yes No

16. Habits: (please circle)

Do you smoke? Yes / No cigarettes / cigars how many per day? _____

If no, have you ever? Yes / No from _____ to _____

Are there smokers in the home? Yes / No If so, do they smoke in the car? Yes / No

Do you use alcohol? Yes / No **Recreational drugs?** Yes / No

17. Review of Systems (Please circle all that apply at the time of this appointment):

General Health: unexplained weight loss or gain, unexplained fevers, poor sleep, heat or cold intolerance

Skin: excessive itch, easy bruising

Eyes, Ears, Nose and Throat: ear pain, hearing loss, nose bleeds, sore throat, hoarse voice, snoring

Heart: heart murmur

Lungs: coughing up sputum

Gastrointestinal: complains of stomach ache, vomiting, diarrhea, constipation, eating difficulties

Kidney/Urinary: pain with urination, blood in urine, frequent urination

Muscles, Bones or Joints: joint pain, joint swelling, broken bones

Nervous System: frequent headaches, seizures, delay in reaching developmental milestones

Mental Health: anxiety, depression, excessive "worry"

Questionnaire including Review of Systems reviewed with patient and/or parent (circle) Yes No

NURSES USE ONLY: HT _____ WT _____ BP _____ PULSE _____ RR _____