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
stuffiness	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_____