Allergy Immunology Clinic of East Bay **(925) 270- 5119**

ALLERGY QUESTIONNAIRE

(you can type in grey fields)

Name:	Date:

How did you find us? Physician (name) Self referral
Website **Other**
Are you seeing another Doctor for this problem? ☐ Yes ☐ No

What is the main problem?

When did symptoms begin? Are symptoms getting worse? ☐ Yes ☐ No

Circle what applies to you:

Eyes, nose throat	Lungs	Digestion	Skin	General	Immune
Tearing	Cough	Abdominal pain	Rash	Headache	Frequent colds
Eye swelling/redness	Troubles breathing	Constipation	Itching	Fatigue	Frequent ear infections
Eye itching	Sputum	Diarrhea	Hives	Night sweats	Skin infections
Sinus infections	Chest pain	Reflux	Acne	Weakness	IVIG infusions
Ear pain	Tight throat	Weight gain	Mastocytosis	Muscle cramps	Frequent antibiotics
Hearing loss	Wheezing	Weight loss	Fragile hair	Sleep problems	Autoimmune disease
Sore throat	Sound breathing	Heartburn	Kelloid	Cold intolerance	Anemia
Postnasal drip	Snoring	Bloating	Baldness	Depression	Pneumonia
	Trouble	Gluten			
Congestion	swallowing	intolerance	Nail problems	Anxiety	Fever
Sneezing		Food allergy	Poison oak	Bruises	Large spleen
Hoarsness		Liver problems		Cancer	Large lymph nodes

Are your symptoms seasonal: ☐ Fall ☐ Winter ☐ Spring ☐ Year-round

Check any of the following which seem to trigger (or cause) symptoms:

☐ Grass ☐ Cats ☐ Dogs ☐ Odors ☐ Exercise
☐ Dust ☐ Perfumes ☐ Smoke ☐ Mold/Mildew ☐ Cold Air
☐ Stress ☐ Cosmetics ☐ Detergent ☐ Creams ☐ Dyes
☐ Alcohol ☐ Coffee ☐ Red wine ☐ _____
☐ Certain food _____

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List any food allergies and reactions experienced:

List any drug allergies (i.e. penicillin, aspirin, sulfa, latex, etc.):

Describe any reaction to insect stings:

Current Allergy or Asthma medications

Drug name	Dose (mg, units)	Frequency (times per day, week)

All other medications:

Drug name	Dose (mg, units)	Frequency (times per day, week)

FAMILY HISTORY

	FATHER	MOTHER	CHILDREN	SIBLINS	OTHER RELATIVE
Nasal allergy					
Asthma					
Food allergy					
Eczema					
Contact reactions					
COPD/Cystic fibrosis					
Rheumatoid disease					
Immune problems					

- Have you been skin tested? ☐ Yes ☐ No
- Have you had allergy shots? ☐ Yes ☐ No
  When: How long:
- Ever receive cortisone drugs (prednisone, methylprednisolone, etc.)? ☐ Yes ☐No
  When How long
- Occupation (current or former)
- Any harmful exposure at work or school:
- Do you smoke? ☐Yes ☐ No How much?
- Have you smoked in the past? ☐ Yes ☐ No When stopped?

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ENVIRONMENTAL SURVEY ***(fill out only if you have allergy or asthma)***

- Do you live in a ☐ House ☐ Apartment How long?
- Approximately how old is your house/apartment?
- Do you have basement? ☐ Yes ☐ No
- Did you have water leaks, mold? ☐ Yes ☐ No
- Type of heating system ☐ Hot Air ☐ Steam (radiator) ☐ Electric
- Have you had ear, nose or sinus surgery ☐ Yes ☐ No
- Do you have: Wood /Coal Stove ☐ Humidifier ☐ Dehumidifier ☐ Air cleaner
- Pets (number) ☐ None ☐Cats ☐ Dogs ☐ Birds ☐Other
- Are there any tobacco smokers in your home? ☐ Yes ☐ No
- Do you have allergy proof encasing for pillow or mattress ☐ Yes☐ No
- What type of pillows do you have? How old is your mattress?
- What type of comforter do you have?
- What floor do you have in your bedroom? ☐ Carpet ☐ Hardwood ☐ Other

PAST MEDICAL HISTORY

Check all that apply:

☐ Diabetes
☐ Peptic ulcer
☐ Cancer
☐ Thyroid disease
☐ High blood pressure
☐ Arthritis
☐ Anemia/blood disorder
☐ Depression
☐ Kidney/bladder disease
☐ Diarrhea
☐ Back problems
☐ Cataracts
☐ Liver disease/hepatitis
☐ Heartburn/reflux
☐ Heart problems/murmur
☐ Seizures
☐ Osteoporosis
☐ Migraines
☐ Asthma
☐ Loss of hearing
☐ Gynecological problems
☐ Anxiety
☐ Glaucoma

- If yes to any of the above, please explain:
- List any hospitalizations or surgical procedures regardless of cause:
- Have you had ear, nose or sinus surgery? ☐ Yes ☐ No
- Have you had your tonsils or adenoids removed? ☐ Yes ☐ No

Add any important information if it was not addressed above:

Questionnaire answered by :_____

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