ENT & Allergy Specialists

INITIAL VISIT ALLERGY QUESTIONNAIRE

Patient's Name: _____ Age: _____ Date: _____
Referring Physician: _____

1. Chief Complaint: (Check your main symptoms)

Head or nose symptoms
- ☐ Sneezing
- ☐ Nose blocking
- ☐ Runny nose
- ☐ Post-nasal drip
- ☐ Sinus infections
- ☐ Sore throat
- ☐ Ear blocking
- ☐ Headache
- ☐ Eye symptoms

Chest symptoms
- ☐ Cough
- ☐ Wheezing
- ☐ Shortness of breath
- ☐ Chest infections
- ☐ Hoarseness or Loss of voice

Skin symptoms
- ☐ Hives
- ☐ Eczema
- ☐ Itching

2. Approximate age of onset: Head or nose symptoms _____ Chest symptoms _____
Skin symptoms _____

3. Indicate the pattern of your symptoms:

	Head/nose	Chest	Head/nose
Year round/no seasonal variation	☐	☐	☐
Year round, worse seasonally	☐	☐	☐
Seasonally only	☐	☐	☐

If seasonal, list months _____

4. Is there any area where you have visited on travel or vacation where your symptoms have improved or disappeared? ☐ Yes ☐ No
If so, list areas: _____

5. Are you allergic to any drugs? ☐ Yes ☐ No
If so, list drugs: _____

6. List medicines you use for relief: _____

7. Have you ever had allergic symptoms from the sting of a bee, wasp, yellow jacket, or hornet, other than local swelling at the site of the sting? (Symptoms such as generalized itching, hives, swelling in areas remote from the sting, hay fever, asthma, nausea, vomiting, etc.) ☐ Yes ☐ No

8. Do you use nose drops or spray? ☐ Yes ☐No
If so, how often? ☐ Frequently ☐ Occasionally ☐ Rarely

9. Have you had skin testing for allergy previously? ☐ Yes ☐ No
If so, give name and location of doctor who performed the testing: _____

10. Have you taken hyposensitization/desensitization/allergy shots previously? ☐ Yes ☐ No
If so, for how long? _____

11. Is there any history of allergic disease in the family tree? (Examples: hay fever, asthma, nasal polyps, hives, "sinus," migraine, eczema, catarrh). ☐ Yes ☐ No If so: Mother's side of family only _____
Father's side of family only _____ Both sides of the family _____

12. Do you have pets at home? ☐ Yes ☐ No If so, what kinds? _____
Keep outside completely _____ Outside some, inside some _____ Inside most of the time _____

13. Do you note increased symptoms from any of the following?

a. Allergens

☐ mowed grass ☐ house dust
☐ dead grass ☐ cats
☐ dead leaves ☐ dogs
☐ hay ☐ feathers

b. Irritants

☐ damp weather ☐ smoke
☐ perfumes ☐ paint
☐ soaps ☐ hair spray
☐ detergents ☐ outside dust

c. Weather changes

☐ windy days
☐ cold fronts
☐ temperature change
☐ damp weather
☐ outside dust

d. Foods (list)

_____
_____
_____
_____
_____

Indicate anything else that increases your allergy symptoms _____
_____

14. If you have cough or wheeze listed as a symptom, how long has it been since you had a chest x-ray? _____

15. Do you smoke? ☐ Yes ☐ No If so, how many packs per day? _____ and for how long? _____

16. Can you take aspirin? ☐ Yes ☐ No If not, why? _____

17. Do you have any other illnesses, or previous hospitalizations? List in order of most recent (List only five. If over 5, tell physician).

Illness or Cause of hospitalization	Age of occurrence
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____

18. Do you have any problems involving your:

	YES	NO
stomach, bowels	☐	☐
heart, blood pressure	☐	☐
nervous system	☐	☐
urinary tract	☐	☐
blood	☐	☐

19. List any medications (including over the counter drugs, creams, suppositories, etc.) you take regularly.
_____
_____
_____