

1. INSTRUCTIONS: Please answer the questions as they relate to the person being evaluated. A complete accurate record is important in learning about your allergy problem. **BRING THIS COMPLETED FORM TO YOUR FIRST APPOINTMENT.**

Briefly describe the reason for your allergy visit and what you hope to accomplish. _____

2. PROBLEMS: Have you ever had any of the following conditions?

Yes	No	(Check All Items)	Age At Onset	Severity			Comments
				Mild	Mod	Sev	
		Asthma (Wheezing)					
		Any Other Breathing Problems					
		Sinus Trouble					
		Hay Fever (Runny, Itchy Stuffy, Nose, Sneezing)					
		Hives or Swelling					
		Eczema or Other Rashes					
		Frequent Infections					
		Food Reactions					
		Drug Reactions					
		Insect Reactions					
		Latex Sensitivity					

Date Reviewed with Patient ____/____/____

Last Name, First: _____

DOB: _____ Age: _____

Medical Record #: _____



Sutter Regional
Medical Foundation
A Sutter Health Affiliate

Allergy Questionnaire

3. SYMPTOMS

Have you ever had any of the following? If not, leave blank.

	# of Days in a Month	Severity			Which Seasons?				Comments
		Mild	Mod	Sev	Winter	Spring	Summer	Fall	
Runny or Stuffy Nose									
Itchy Nose									
Sneezing									
Itchy Eyes									
Wheezing									
Coughing									
Wheezing or Coughing with Exercise									
Skin Problems									

4. PRECIPITATING FACTORS / TRIGGERS:

For each item below, check the appropriate square to indicate whether you (or your child's) condition is affected by the following precipitants / triggers.

	Condition Made Worse	Condition Improved	No Change		Condition Made Worse	Condition Improved	No Change
Cutting or playing in grass, raking leaves	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Strong odors: Specify: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High winds, riding in auto	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Exposure to animals Specify: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Moldy/mildewed areas or items	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Physical exertion or exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sweeping, dusting or vacuumi Smog, Smoking or smoke exposure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cold weather	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tobacco Smoke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other factors			
Travel (Where): _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
"Colds" or viruses	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				

5. PREVIOUS ALLERGY EVALUATION AND THERAPY

Have you ever had allergy skin tests: Yes No

If yes, give date: _____ Physician's Name _____

Results of these test: (if possible, please provide us with a copy)

Have you ever received allergy injections? Yes No Did they help? Yes No

If yes, give dates: _____

Please list all medication and treatments you have taken for allergies (current and past).

Did they help?

Yes No

	Yes	No

Name :

DOB:

Date Reviewed with Patient ____/____/____

6. PAST MEDICAL HISTORY

List All Other Chronic Medical Conditions:

When First Diagnosed:

_____	_____
_____	_____
_____	_____

Hospitalization / Surgery (List Most Recent First):

Type:

Reason:

Date:

_____	_____	_____
_____	_____	_____
_____	_____	_____

Current Medications (Prescription and Over-The-Counter):

Name:

Dose and Frequency:

Date First Started:

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Medication Allergy:

Medicine:

What Happens:

Date Last Taken:

_____	_____	_____
_____	_____	_____

7. SOCIAL HISTORY

Marital Status

Occupations

_____	_____
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Residences (List Most Recent First):

City & State

Dates:

Effect On Symptoms (Better, Worse, No Change):

_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you ever smoked?

Yes

No

Alcohol Use:

Yes

No

If yes, how many years? _____

If yes, how many drinks per day _____

Do you presently smoke?

Yes

Packs per day _____

No

Does anyone smoke in your

When did you stop? _____ (Congratulations!)

household? Yes No

Average cigarettes per day at highest point? _____

Name :

DOB:

Date Reviewed with Patient ___/___/___

8. ENVIRONMENTAL SURVEY

Age of house: Years	Do you have: (a) an air cleaner? (b) an air dehumidifier?	Are any rooms damp or musty?
Do you have any: stuffed furniture? _____ Feather comforters? _____	How old is your mattress?	
Is your pillow: <input type="checkbox"/> feather <input type="checkbox"/> synthetic <input type="checkbox"/> encased in plastic	What plants, if any, contributed to your symptoms:	
List number and kind of pets (dog, cat, birds, horses, etc.) How long?	Do any of your pets spend time indoors? <input type="checkbox"/> Yes <input type="checkbox"/> No	
What type of work do you do?		
Are you exposed to anything at work that might aggravate your condition? Which things?		
Have you missed any time from work or school because of your allergies? How much time?	Do you have any other exposures from hobbies, recreational activities, etc.?	

9. FAMILY HISTORY

Do any members of your family have a history of allergy?

If yes, list all relatives (e.g. parents, brothers and sisters, children, aunts, uncles, grandparents, etc.)

	Yes	No	
Asthma			
Hay Fever			
Eczema			
Hives/Swelling			
Frequent Infections			
Other Allergies			

10. REVIEW OF SYSTEMS: Have you ever had any of the following? Please explain.

Skin Problems (Non-allergic) _____

Eye Problems _____

Frequent Ear/Throat Infections _____

Chronic Lung Disease or Infection _____

Heart Problems or High Blood Pressure _____

Intestinal Problems or "Heart Burn" _____

Kidney or Bladder Problems _____

Psychiatric Problems or Depression _____

Diabetes or Thyroid Problems _____

Blood Count Problems (Anemia, Etc.) _____

Name : _____ DOB: _____ Date Reviewed with Patient ____/____/____