

Allergy Questionnaire

Patient Name: _____ Date: _____

Date of Birth: _____ Patient # _____

Please check the boxes that apply:

1. Does your nose feel.....

	Never	Sometimes	Usually	Constantly	Seasonally
Stuffy					
Runny					
Itchy					
Post-Nasal Drip					

2. Do your Ear(s) feel.....

	Never	Sometimes	Usually	Constantly	Seasonally
Stopped Up					
Itchy					
Sore					
It Discharges					

3. Do you have Nasal Blockage.....

	Never	Sometimes	Usually	Constantly	Seasonally
Alternating Sides					
Daytime					
Nighttime					
Seasonal (Check all that apply)	Winter _____	Spring _____	Summer _____	Fall _____	Year round _____

4. Do your Eyes.....

	Never	Sometimes	Usually	Constantly	Seasonally
Water					
Itch					
Feel Swollen					
Burn					

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5. Do you sneeze frequently?

	Never	Sometimes	Usually	Constantly	Seasonally
Seasonally					
Daytime					
Nighttime					

6. Do you cough?

	Never	Sometimes	Usually	Constantly	Seasonally
Seasonally					
Daytime					
Nighttime					

7. During what Months do you have the above symptoms? (Check all that apply)

<input type="checkbox"/> January	<input type="checkbox"/> April	<input type="checkbox"/> July	<input type="checkbox"/> October
<input type="checkbox"/> February	<input type="checkbox"/> May	<input type="checkbox"/> August	<input type="checkbox"/> November
<input type="checkbox"/> March	<input type="checkbox"/> June	<input type="checkbox"/> September	<input type="checkbox"/> December

8. Which month do find these symptoms most severe? (Check all that apply)

<input type="checkbox"/> January	<input type="checkbox"/> April	<input type="checkbox"/> July	<input type="checkbox"/> October
<input type="checkbox"/> February	<input type="checkbox"/> May	<input type="checkbox"/> August	<input type="checkbox"/> November
<input type="checkbox"/> March	<input type="checkbox"/> June	<input type="checkbox"/> September	<input type="checkbox"/> December

9. How many colds do you usually have per year? _____

10. Have you ever smoked? If yes, please answer the following questions:

- a. How many cigarettes per day? _____
- b. How many cigars per day? _____
- c. How many times a day do you smoke a pipe? _____
- d. How many years have you been smoking? _____
- e. If you quit, when did you quit smoking? _____

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11. Do you have any pets or are exposed to pets on a regular basis? ___ Yes ___ No
a. ___ Cats, How Many? _____
b. ___ Dogs, How Many? _____

12. Do you have any extreme reactions to insect bites? (Check all that apply)

- _____ Bees
- _____ Wasps
- _____ Spiders
- _____ Snakes
- _____ Ants
- _____ Other _____

- a. Have you been hospitalized for this reaction? ___ Yes ___ No

13. What type of dwelling do you live in and where is it located?

- | | |
|--------------------|----------------|
| _____ Single House | _____ City |
| _____ Duplex | _____ Suburban |
| _____ Apartment | _____ Rural |
| _____ Trailer Home | _____ Farm |

14. What prescription and non-prescription medications do you take on a regular basis?

15. What medications relieve your allergy symptoms?

16. Please use the space provided below to tell us anything you would like us to know about your allergy problems.

