



PATIENT QUESTIONNAIRE: PLEASE REMEMBER TO SIGN AT BOTTOM OF PAGE 2!!!

Patient Name: _____ Date of Birth: _____ Age _____ Sex _____
 Referred By: _____ Primary Doctor: _____

Please answer all questions on this form. A complete history is very important in learning about your allergy problem.

1. Briefly describe the reason for your visit and what you hope to accomplish:

2. SYMPTOMS:

Nose:	Runny nose	Sneezing	Itching	Stuffy nose	Sniffing
	Nosebleeds	Mouth Breathing	Snoring	Loss of smell or taste	
Throat:	Postnasal drip	Sore throats	Throat clearing	Hoarseness	Itching
Sinus:	Headaches	Bad breath	Sinus infections	Frequent colds	Pressure
Ear:	Fullness	Pain	Itching	Hearing loss	Ear Infections
Eyes:	Redness	Itching	Watering	Puffiness	Discharge
Skin:	Rash	Hives	Eczema	Itching	Dryness
Chest:	Coughing	Wheezing	Tightness	Shortness of breath	Bronchitis

How long have you had these symptoms? _____

What medications have you tried for this condition (nose spray, antihistamine, inhaled asthma med, topical)? _____

Did they help / not help / could not tolerate? _____

SYMPTOMS AFFECTED BY:

Location: Indoor Outdoor Home Office Vacation **Time of Day:** Morning Afternoon Evening Night All the Time
Seasons: Spring Summer Fall Winter All Year **Weather:** Hot Cold Dry Humid Sunny
Fumes: Perfumes Cleaners Cigarette Smoke Paint Cooking Chemical odors Newsprint
Dust: House dust Cat dander Dog dander Pollen Cut grass Mold/Mildew
Other factors: Exercise Medication Insect Sting Foods / Food Additives Pets Cosmetics Laughing Stress With Infections

PAST MEDICAL HISTORY:

Please list **Medical Problems:**

Hospitalizations/ER and Surgeries:

MEDICATIONS: (you may attach list if you have one) _____

If you have ECZEMA, what Soap _____ Lotion _____ Topical med _____

SOCIAL HISTORY: Do you have any PETS? List number and kind (**DOG / CAT / BIRD**) _____ INDOOR / OUTDOOR _____

Where were you born? _____ Raised? _____ When did you move to Florida? _____

Have you ever smoked? Yes /No If yes, how many years? _____ Still smoke? _____ Quit? _____

Does any household member smoke? _____ If so, specify _____



SOCIAL HISTORY (THIS SECTION ONLY FOR ADULTS):

Are you married _____ single _____ divorced _____ How many children do you have? _____ Their ages: _____

Do you drink alcohol? Yes /No How often: _____ How much? _____

Do you use any drugs? Yes /No If yes, specify _____

EMPLOYMENT HISTORY: What is your occupation? _____ Current Employer? _____ Since _____

Are you exposed to chemicals or smoking at work? _____

Are you symptoms worse at work? Yes / No If yes, specify _____

Have you missed any time from work because of your allergies? Yes / No If so, how much time? _____

FAMILY HISTORY:

Do any family members have a history of allergy? If yes, list all relatives and their ages:

Asthma _____

Allergic rhinitis _____

Eczema _____

Hives _____

Do any family members have medical problems? If yes, list all relatives and their ages:

Hypertension _____ Diabetes _____

Heart attack _____ Cancer _____

BIRTH HISTORY: (THIS SECTION ONLY FOR CHILDREN <18 years old):

Born Full Term / Pre – Term ? How many weeks Pre –Term? _____ Complications at birth? _____

Immunizations Up To Date? Y / N Development Normal? Y / N Growth Normal ? Y / N Daycare ? Y / N _____

ENVIRONMENTAL HISTORY: Do you live in a / an: House _____ Apartment _____ Condo _____ Mobile home _____

Is it located on near: The water _____ Age of house: _____ How long you have been living there? _____

Is there any mildew? _____ cockroaches? _____ Type of Air conditioning: Central, Window, etc. _____

Type of filters: Regular, HEPA, etc. _____ Type of flooring: (carpet, wood, tile, vinyl, etc.) _____ Age of carpet? _____

Is carpet throughout _____ In bed rooms _____ in living room _____

How old is your mattress? _____ Is your mattress: foam _____ encased in plastic _____ waterbed _____ other _____

How old is your pillow? _____ Is your pillow: feather _____ encased in plastic _____ synthetic (Dacron) _____ foam _____ other _____

ALLERGIC HISTORY: Are there any foods that you cannot eat for any reason except for taste? If so, which and Why?

Are there any medications that you cannot tolerate? _____

If so, Which and Why? _____

Have you ever had a reaction to X-ray dye? _____ Have you ever had a reaction to latex products (i.e. glove, balloon, etc)? _____

Have you ever had a serious allergic reaction (shortness of breath, wheezing, hives, dizziness and fainting etc.) after an insect sting? (wasp, honey bee, yellow jacket, fire ant, etc.). If so, please specify _____

PREVIOUS ALLERGY EVALUATION AND TREATMENT:

Have you ever had allergy skin testing? Yes / No If Yes, date: _____ Physician's Name: _____

What did the skin testing show? _____

Have you ever received allergy injections? Yes/ No If yes, dates: _____

Did your symptoms improve with allergy injections? Yes / No

Have you ever had an adverse reaction to an allergy injection? Yes /No

If yes, please specify: _____

Signature of Patient/Parent/Guardian

Name of Patient/Parent/Guardian

Date