ALLERGY HISTORY QUESTIONNAIRE

PATIENT'S NAME: _____DOB: _____ Today's Date: _____

****PLEASE USE BLACK INK ONLY****
ALL QUESTIONS MUST BE ANSWERED

1. **Do you have a family history of allergies? ___ yes ___ no ___ one side of family or ___ both sides**

2. **Describe your symptoms (most bothersome to least): _____**
   _____

3. **Are your symptoms? _____continuous _____ variable _____ year around _____or seasonal in nature**

4. **Is there a worse time of day for your symptoms? _____**

5. **If your symptoms are seasonal, which months are the worst? _____**

6. **Is there a place that you're worse, such as home, school, or work? _____**
   If yes, where _____ Describe the environment: _____
   _____
   How are your symptoms worse there? Describe: _____
   _____
   Type of employment _____ Describe school _____

7. **Describe the buildings you live and work in (new, old, damp, excessively dry, heating & cooling, etc.):**
   _____
   _____

8. **Do you have pets? ____ yes ____ no**
   If yes to this question, what pets do you have? _____

9. **What exposures or changes in your environment do you know, or suspect make your symptoms worse or for that matter better? _____**
   _____

10. **Do you have, or have you ever been diagnosed with Asthma _____ yes _____no**

11. **Do you have any allergies you know of or suspect to medications or other substances? If yes, please list:**
    _____
    _____

12. **Are you taking any drugs, medications, eye drops, herbs, or vitamins? Please list <u>ALL</u> of these:**
    _____
    _____

13. **Is there a possibility that you are pregnant or are you considering this in the near future? ___yes __no**

14. **Have you taken allergy shots before? ____ yes ____ no If yes, did they help? ____ yes _____ no**

15. **Have you ever had a whole body, life threatening, allergic reaction? ____ yes ____ no If yes, please describe this reaction _____**
    _____

16. **Do you smoke, have you smoked, or have smoke exposure? ____yes ____ no**

Signature of the patient, if not a minor: _____