ALLERGY CONSULTANTS

PATIENT (PARENT) QUESTIONNAIRE

Patient's Name _____ Birth Date_____

Referred by:_____ Primary Care Physician: _____

1. **MAJOR PROBLEM(S):**
   - A. (Please List) 1._____ 2. _____ 3. _____
   - B. Year of Onset 1._____ 2. _____ 3. _____
   - C. In past year, problems are (pick one):_____ worse, _____ same, _____ better.
2. **PAST MEDICAL HISTORY:**
   - A. Other Medical Problems:_____ _____ _____
   - B. Hospitalizations: Number: _____ Reasons and Dates: _____
     _____
   - C. Surgeries?_____ No. If yes, specify and give year: _____
   - D. If Patient is Child: Birth Wt. _____ Breathing problem at birth?_____ Yes _____ No
     As infant, patient had: _____ colic, _____ eczema, _____ many formula changes,
     _____ constant runny nose, _____ breathing problems.
     Immunizations complete? _____ Yes _____No. Adverse reactions? _____
3. **PERSONAL HISTORY:**
   - A. Is patient in school? _____ Yes _____ No. Grade _____ Name of School _____
     _____ Type Student: _____ Average _____ Above Average _____ Below Average.
     Number school days missed last school year. _____ this school year. _____
   - B. Is patient employed? _____ No _____ Yes Occupation: _____
   - C. If preschool age, does patient spend time at _____ preschool/day care _____ babysitter.
     How much time? _____ When did day care begin? _____
   - D. If older child or adult, does patient smoke? _____ Yes _____ No.
   - E. Hobbies? _____
4. **ALLERGIC HISTORY:**
   - A. Check any of the following symptoms that patient had or now has:

NOSE/THROAT
_____ Frequent colds
_____ Frequent congestion
_____ Postnasal drainage
_____ Runny nose
_____ Chronic Sniffing
_____ Frequent sneezing
_____ Freq. rubbing/itching
_____ Frequent sore throats
_____ Nosebleeds
_____ Sinus infections
_____ Headaches
_____ Nasal polyps
_____ Snoring

EYES
_____ Redness
_____ Itching/rubbing
_____ Watering
_____ Swelling
_____ Dark circles

CHEST
_____ Frequent cough
_____ Shortness of breath
_____ Wheezing
_____ Wheezing attacks
_____ Tightness in chest
_____ Exercise intolerance
_____ Sputum or phlegm
_____ Pneumonia
_____ Bronchitis
_____ Frequent croup
_____ Symptoms cause awakening from sleep
How often? _____

EARS
_____ Frequent infections
_____ Fluid
_____ Ear tubes
_____ Hearing loss
_____ Speech problem

SKIN
_____Eczema
_____Hives (welts)
_____Dryness
_____Frequent rashes
_____Itchy

MISCELLANEOUS
_____Tires easily
_____Irritable
_____Poor weight gain
_____Weight loss
_____Fevers
_____Bad reaction to insect bites
_____Bad reaction to insect stings
_____Reaction to latex

B. **FACTORS AFFECTING ALLERGIES/PROBLEMS.** Base responses on your observation, not on what you have been told by others.

	BETTER	WORSE	NO CHANGE
Dec.-Feb.			
Mar.-Apr.			
May-June			
June 15- Aug 15			
Aug 15-Oct 1			
Oct.-Nov.			
Morning			
Afternoon			
Evening			
After bedtime			
Inside house			
Outside house			

	BETTER	WORSE	NO CHANGE
Basement			
At school or work			
Out of town			
Dust			
Smoke			
Strong odors			
Cold weather			
Damp weather			
Wind			
Weather Change			
Colds/Infection			

	BETTER	WORSE	NO CHANGE
Running			
Exercise			
Swimming			
Fatigue/Tension			
Cats			
Dogs			
Other animals			
Grass/Mowing			
Leaves/Raking			
Hay			
Air Condtng.			

C. Any drug reactions (including aspirin)? _____ List drug and reaction to it: _____

_____

D. Any problems with foods? _____ List food and reaction to it. _____

_____

E. Previous treatment of allergies/problems. Please check any of the following medicines or types of medicines used. and the effect they had on the problem(s).

		Better	Worse	No Effect
1.	Antihistamines (Allegra, Benadryl, Clarinex, Claritin, Xyzal, Zyrtec)	_____	_____	_____
2.	Decongestants (Sudafed)	_____	_____	_____
3.	Nasal Sprays (Rx) (Astelin, Astepro, Flonase, Nasacort, Patanase, Rhinocort)	_____	_____	_____
4.	Nasal Sprays (non-prescription): (Afrin, Nasalcrom)	_____	_____	_____
5.	Eyedrops	_____	_____	_____
6.	Bronchodilator Inhalers (Albuterol, Pro Air, Xopenex)	_____	_____	_____
7.	Steroid Inhalers (Arnuity, Asmanex, Flovent, Pulmicort, Qvar)	_____	_____	_____
8.	Combination Inhalers (Advair, Breo, Dulera, Symbicort)	_____	_____	_____
9.	Breathing treatments (Albuterol, Pulmicort, Xopenex)	_____	_____	_____
10.	Singulair	_____	_____	_____
11.	Steroids (Orapred, Prednisone)	_____	_____	_____
12.	Cough Medicine	_____	_____	_____
13.	Antibiotics (Amoxicillin, Augmentin, Biaxin, Septra, Z-Pak)	_____	_____	_____
14.	Allergy Shots	_____	_____	_____

F. List all current medications and doses_____

_____

G. Previous allergy tests? _____ Yes _____ No. By whom? When? Findings?

_____

H. Check any of the following that patient has had. Indicate year and place done.

Chest x-ray_____ Lung Function test _____

Sweat test _____ Hearing tests _____

Sinus x-ray/CT Scan _____ Immunity blood tests _____

5. **ENVIRONMENT**

A. Do you live in: _____ Suburbs _____ City_____Country (rural)

_____near woods _____near fields _____ near air pollutants_____ industry?

B. Do you live in: _____ house_____apt? How long? _____ yrs. Age of dwelling:_____

C. Check those that apply:

_____Basement-damp
_____Basement-dry
_____Bsmt.-occas. damp
_____Heat: forced air
_____Heat: other
Type _____
_____Smoking in home

_____ Humidifier
_____ Dehumidifier
_____ Air purifier
_____ Air cond.
_____ Attic Fan
_____ Vaporizer used
_____ Plants
approx. no. _____

_____ Pets (in house) Type?
_____
_____

_____ Pets or animals (outside)
_____
_____

_____ Favorite stuffed chair or couch in family room

D. Patient's Bedroom:

Does patient_____ share bedroom_____ sleep alone _____ bedroom in basement?

Check any of the following that are in the patient's bedroom:

_____ Heating duct
_____ Room Heater
_____ Air Cond.
_____ Curtains/Drapes
_____ Mini Blinds/Shades
_____ Wood Blinds
_____ Crib Mattress
_____ Regular mattress
_____ Foam/Tempurpedic

_____ Plastic pillow cover
_____ Plastic mattress cover
_____ Plastic box spring cover
_____ Feather pillow
_____ Foam pillow
_____ Synthetic pillow

_____ Other blanket
_____ Down synthetic comforter

_____ Stuffed animals
_____ Stuffed furniture
_____ Bean bag chairs
_____ Shelves
_____ Books
_____ Plants
_____ Aquarium/terrarium
_____ Pets

_____ Wood flooring
_____ Tile flooring
_____ Wool carpet/rug
_____ Synthetic carpeting

Bed Sheets washed how often:
_____

Bedroom dusted how often?
_____

6. **FAMILY PROBLEMS:** Check which apply and specify relationship to patient: Father (F) or Mother (M), brothers (B), sisters (S), children (CH), grandparents (GF, GM), aunts (A), uncles (U), cousins (C).

_____ Asthma_____
_____ Bronchitis _____
_____ Nasal Allergies/Hay Fever _____
_____ Sinus Trouble _____
_____ Skin allergy/Eczema_____
_____ Migraine headaches_____

_____ Hives (welts)_____
_____ Cystic Fibrosis _____
_____ Emphysema _____
_____ Tuberculosis _____
_____ Repeated infections _____
_____ Food Allergies_____