ALLERGY CONSULTANTS
Caring For Your Health For Over 40 Years

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 a 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-Cigarettes/Vaping? _____ Yes _____ No

E. Hobbies? _____

4. ALLERGIC HISTORY:

A. Check any of the following symptoms that patient <u>had</u> or now <u>has</u>:

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

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

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? _____

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, Patanase)			
4. Nasal Sprays (steroid): (Flonase, Nasacort, Rhinocort)			
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 (Montelukast)			
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
_____ Down (feather) comforter
_____ Synthetic comforter
_____ Other blanket
_____ 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 _____