Allergy Clinic Questionnaire

What problem brings you to this appointment?
__________________________________________________________________________________________________________

When did symptoms begin? ____________________________________________

Are symptoms getting worse?  Yes  No

Do you have any of these symptoms?  (Please check)

- Cough
- Wheezing
- Shortness of breath
- Chest tightness
- Sneezing
- Runny Nose
- Nasal Congestion
- Itchy Nose
- Itchy / Watery Eyes
- Postnasal Drip
- Phlegm / Sputum
- Nasal Polyps
- Poor Sense of Smell
- Ear Infections
- Sinus Infections
- Blocked Ears
- Eczema
- Hives / Swelling
- Headaches
- Snoring
- Fatigue
- Other

Check any of the following which seem to trigger (or cause) symptoms or bother you:

- Grass
- Hay
- Mold and Mildew
- Basements
- Leaves
- Cats
- Dogs
- Horses
- Other animals
- Alcoholic beverages
- Cosmetics
- Aerosol sprays
- Perfumes
- Insecticides
- Odors
- Drafts
- House dust
- Smoke
- Pollution
- Exercise
- Nervousness
- Cold Air
- Humidity
- Weather Changes
- Latex (rubber)

When are your symptoms worse?  Year Round

- January
- February
- March
- April
- May
- June
- July
- August
- September
- October
- November
- December

Are symptoms better away from home?  No  Yes  If yes, when? _______________________________

Have you been skin tested?  No  Yes  If yes, results? _______________________________

Have you had allergy injections?  No  Yes  If yes, when? _______________________________

Have you received cortisone (prednisone, methylprednisolone, etc.) drugs?  No  Yes

When: _______________________________  How much: _______________________________

Occupation (current or former) _______________________________________________________________________

Any harmful exposure at work or school   _______________________________________________________________

Environmental Survey

Ave you completed HBE’s environmental checklist?  Yes  No

If YES? What did you find out? ________________________________________________________________

If YES? Was anything helpful? ________________________________________________________________

For more information call 505-844-HBES (4237) or visit hbe.sandia.gov
Your Past Medical History

- Diabetes
- Liver disease/hepatitis
- Peptic ulcer
- Heartburn/reflux
- Emphysema
- Cancer
- Heart problems/murmur
- Thyroid disease
- Seizures
- High blood pressure
- Osteoporosis
- Arthritis
- Migraines
- Anemia/blood disorder
- Gynecologic problems
- Hay fever
- Depression
- Kidney/bladder disease
- Glaucoma
- Diarrhea
- Anxiety
- Back problems
- Asthma
- Cataracts
- Loss of hearing

If yes to any of the above, please explain: ____________________________________________________

Have you had your tonsils or adenoids removed?  Yes  No
Have you had ear, nose or sinus surgery?  Yes  No  If yes, explain _________________________________

Allergy History

List any food allergies and reactions experienced: __________________________________________________________________________________________

List any drug allergies and reactions experienced (i.e. penicillin, aspirin, sulfa, latex, etc) ______________________________________________________________________

Describe any reactions in insect stings: ____________________________________________________________

______________________________________________________________________________________________

Medications

List all medications and dosages (including nasal sprays, non-allergy medications and alternative/herbal products):

______________________________________________________________________________________________

______________________________________________________________________________________________

Smoking History

Do you smoke?  Yes  No  If yes, how much? ________________________________

Have you smoked in the past?  Yes  No  If yes, how many years and when stopped? ________________________________

Date: ________________________________  Questionnaire reviewed: ________________________________