ALLERGY HISTORY QUESTIONNAIRE
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MEDICATION INSTRUCTIONS: Benadryl and other store brand antihistamines and decongestants must be stopped three days prior to skin testing. Antihistamines that need to be stopped for 7 days prior to testing are Xyzal, Zyrtec, Claritin, Clarinex, and Allegra. If you have concerns stopping any of your medications, please contact our office at (406) 728-6472.

Please complete this questionnaire and bring it with you to your appointment. If the question does not apply to the patient, fill in "NA".

Patient Name:________________________________ Age: __________ Birth date: ______________
Parents Name (if patient is a child):________________________________
Address:________________________________ Phone:________________
Referring Physician: ________________________________

A) Reason for Evaluation
1) Please summarize briefly your MAIN concerns (This is the most important question.):

2) What symptoms do you feel may be due to allergy? ________________________________
____
3) Age symptoms began ________

B) If patient wheezes, complete the following:
1) With what symptoms does the wheezing problem begin?________________________________
2) List the symptoms which then appear in order of occurrence:________________________________
____
3) At what age did the wheezing begin?________________
4) Has it improved?__________ Worsened? ________To what do you attribute this?________________
5) When do the symptoms seem worse? All Year________ Spring ________ Summer ________ Fall ________ Winter ________
6) Wheezing episodes occur ________days per week during wheezing periods.
7) When does the wheezing usually occur? Morning__________ Afternoon __________ Evening __________
8) How long does the wheezing period last? ________________________________
9) How often are there **severe wheezing** episodes?________________ How long do the severe episodes last?__________
10) Check the items which apply: Occasional wheezing ______ Frequent wheezing______ Constant wheezing ______ Cough leading to wheezing______
Fever with wheezing______ Wheezing with exertion________ Chest pain with wheezing________
11) What medications have been used to control the wheezing and how effective is each?________________
____
12) Did any medications cause any problems?________________________________
13) Has any of the following been given to control the wheezing? Adrenalin__________ Cortisone or cortisone-like drugs________________
14) Has the severity of an attack required hospitalization? No______ Yes______ When? ________________ Where?________________
What was the treatment?________________________________

C) Nose
1) Check the items which apply to nasal symptoms: Itching of nose or mouth______ Nasal congestion______ Clear nasal discharge ______
Colored nasal discharge _____Fever with symptoms _____ Mouth breathing _____ Constant clearing of the throat_____ Sneezing ______
Bad breath _____ Post nasal drip______ Loss of smell _____ Nasal polyps _____ Snoring _____ Sinus infections _____
2) At what age did these symptoms start?____________
3) When do the symptoms seem worse? All year______ Spring _____Summer _____ Fall _____ Winter _____
4) What medications have been used to control these symptoms and how effective is each? ________________________________

D) **Infections**

1) How many "colds" occur per year? ____________With wheezing?_________
2) How often does tonsillitis occur each year?_______ With wheezing? ______Has patient had tonsillectomy? (yr)______ Adenoidectomy? (yr)______
3) Have there been episodes of: Croup?_____ Bronchiolitis?______ Bronchitis? _____ Pneumonia?______ Chest Infections (date of last)__________
4) What antibiotics have been used to treat infections? ____
5) List any antibiotics the patient is allergic to or has had any unusual side effects to:______________________________
____

(E) **Headaches**

1) Seldom__________ Occasionally ___________ Frequent _____________

(F) **Eye Complaints**

1) Check symptoms that apply to patient: Frequent itching_________ Frequent redness and tearing_________ Swelling of eye lids_________
Discharge from eyes_________ Sensitivity to light _________ Blurring of vision________ Burning sensation__________
2) How often have these symptoms been a problem within the past year?______________________________________

(G) **Ear Complaints**

1) Check symptoms that apply to patient: Frequent earaches_______ Loss of hearing_______ Ear infections_______ Dizziness_________

(H) **Skin**

1) Check symptoms that apply to patient: Eczema________ When?_________________ Due to what?______________________
Recurrent Rash__________________ Hives_________ When?______________ ___Due to what?______________________
Frequent skin infections (impetigo)__________________________ Dry or itchy skin?___________________________

(I) **Foods**

1) Check any of the following that foods cause: Itching of the lips or mouth___________ Itching of the skin__________ Hives______________
Eczema_________ Rash________ Headaches________ Runny Nose_______ Nausea/vomiting________ Wheezing_______
Stomach cramps________ Diarrhea_______ Other____
2) Have any foods been eliminated from the diet?____
3) Did this change the severity of symptoms?____
4) Is there a large intake of any particular food or beverage?_____________________________________

(J) **Precipitating factors of coughing, wheezing, nasal congestion, or sneezing**

1) Check the items or situations that will cause any of the above symptoms to start or become worse:

_____outdoors	_____home/indoors	_____cosmetics/perfume	_____January
_____wet weather	_____cleaning house	_____hairspray	_____February
_____dry clear weather	_____contact with old furniture	_____hair shampoos/rinses	_____March
_____change from clear to rainy	_____attic/basement	_____hand/facial lotions	_____April
_____change from rainy to clear	_____air conditioning	_____body/facial powders	_____May
_____sudden change in temp	_____contact with dogs or cats	_____toothpaste/tooth powder	_____June
_____onset of cold weather	_____contact with other animals	_____aspirin	_____July
_____change in humidity	_____contact with feathers/wool	_____laundry soap powder	_____August
_____sudden chilling	_____newly mowed grass	_____flour dust	_____September
_____cold feet	_____while on vacation	_____insect dust/sprays	_____October
_____exertion	_____seashore	_____fertilizers	_____November
_____fatigue	_____boat/airplane ride	_____smoke or odors	_____December
_____laughing	_____school/work/recreation	_____old leaves	
_____coughing	_____being in the woods/mountains	_____flowers	
_____emotional upset	_____car ride	_____road dust	
_____child discipline	_____other	_____same everywhere	

2) Does anything from the list above (or anything else) cause improvement or worsening of symptoms?_______________________
____

(K) **Problems the symptoms create for the patient**:

1) Is there limitation of work?________ _____exercise?_____________ play?_____________
2) Due to what symptoms?____
3) How many work/school days were missed during the past year due to this problem?_______________________
4) Have there been any long periods of freedom from symptoms?_______________________________
5) To what do you attribute this?____
6) Is there any place where the patient is symptom free?_______________________________

(L) **Residence when onset of symptoms occurred**

1) State___________________________ Date of residence________________________
2) Symptoms were: Seasonal________________ Year round______________________ How severe?__________________________

(M) **Previous allergy evaluations**

1) Place evaluated before____ Date__________________________
2) What were the results?____
3) Have allergy injections been received in the past? No_____ Yes_____ Give the start and stop dates of desensitization__________ to_________
4) What was the composition of allergy injections?_______________________________________
5) Was there improvement after taking allergy injections for a period of time? No_______ Yes_______
6) Other studies done:____

(N) **Allergic Reactions**

1) What type of reaction occurs when stung by a bee or wasp?_______________________________
2) List drug allergies or intolerances: 1)______________________________ 2)______________________________
   3)______________________________ 4)______________________________ 5)______________________________

(O) **Personal Medical History**

1) List any other medical conditions: 1)____
2)____
   3)______________________________ 4)______________________________ 5)______________________________
2) Does the patient have a heart condition or heart arrhythmia? (Please specify)_______________________________
3) Check immunizations that have been completed: DPT series________ Polio series _________ MMR________ Hepatitis B series_____________
   Varicella__________ Hib series__________

(P) **Family History**

	Father	Mother	Brothers	Sisters
1) Age				
2) Hay fever				
3) Asthma				
4) Eczema				
5) Hives				
6) Sinus trouble				
7) Heart Condition				

8) Does any member of the family have a chronic illness? (specify)_______________________________
9) List any other medical problems you feel may be of importance.______________________________
10) Is there any family member deceased?______________________________ Cause?______________________________
11) Does any illness seem to occur on either side of the family?_______________________________

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(Q) Environmental History (where patient lives and what he is exposed to)

1) Residence: Check which applies to your home. Urban_____ Rural_____ Farm_____ Older House_____ Newer House______ Apartment__________
2) Does home have an attic? (describe)____________________________basement? (describe)______________________________________
3) Is home near a factory? (describe)____farm? (describe) ____________________________________
   fields or wooded areas (describe)____
4) Type of trees in your yard and neighborhood?____
5) Type of grass, flowers, or shrubs in the yard?____
6) Check which applies to the residence's heating system: central_______ hot water________ electric__________ gas__________ wood__________
7) Check which applies to the residence's cooling system: none________ central AC________ window unit AC__________ swamp cooler__________
8) What kind of pets are in/out of the home?____
9) What kind of house plants are in the home?____
10) Does anyone smoke in the home or car? Yes__________ No____________ Specify ____
11) Is there any place in the home where patients symptoms are worse?____
12) Check the following that pertain to the patient's bedroom: heat or cooling vents________ overstuffed furniture________ stuffed toys__________
    cosmetics/powders/hairspray__________ scented products (e.g. candles, potpourri)__________ out of season clothes in closet_____________
    airtight covers for pillows/mattress__________________________________
13) Check and describe type for any of the following items that are in the patient bedroom:
    Carpet/rug pad:____
    Throw rugs: ____
    Curtains:____
    Mattress:____
    Pillows:____
14) Number of beds in room:__________________ Number of persons sleeping in room__________________
15) Is there mold growing anywhere in the house (describe)?____
16) Is there anything in your house or yard/around residence that has not been mentioned that you think is significant in contributing to the patient's symptoms?____
    ____
17) What changes have you implemented to the patient's environment to improve his/her symptoms?_______________________________________
    ____

(R) **Other Comments:**

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