

Mike S. Shin, MD

Allergy History/Patient Questionnaire

Patients Name _____

Sex: _____

Date: _____ Age _____

Please answer the following questions as accurately as possible. Your answers will help us determine the cause of your allergy symptoms.

	Yes	No	?
Trouble with your skin?			
Eczema			
Hives			

	Yes	No	?
Trouble with your ears?			
Popping			
Itching			
Hearing Loss			
Fluid in Ears			
Infection/Pain			

	Yes	No	?
Trouble with throat?			
Frequently sore/drainage			
Itching throat/mouth			

	Yes	No	?
Trouble with eyes?			
Redness			
Itching			
Tearing			
Puffiness			

	Yes	No	?
Trouble with nose?			
Clear/colorless discharge			
Thick/colored discharge			
Nasal itching/rubbing			
Constant stuffiness			
Sniffles			
Sneezing			
Mouth breathing or snoring			

	Yes	No	?
Are your symptoms mild?			
Moderate			
Severe			
Present most of the time			
Present part of the time			
Present rarely			
Interfering with your life			
Preventing may normal activities?			
Please specify below			

	Yes	No	?
Trouble with chest?			
Wheezing with colds			
Wheezing when exposed to dust pollen, animal, etc			
Wheeze/cough after exercise			
Cough			
Deep or productive			
Loose			
Constant			
Dry/tight			
Daytime			
Nighttime			

	Yes	No	?
Which of the following cause or aggravate your symptoms?			
Indoors			
Outdoors			
At home			
At work			
Morning			
Afternoon			
At night			
Weather change			
Dry weather			
Windy day			
Hot day			
Cold day			
Air conditioning			
In barns			
Damp areas			
Hay, circus			
Mowing lawn			
Dusty environment			
High air pollution			
Animas			
Cooking odors			
Smoke			
Soap powder			
Insecticides			
Paint fumes			
Perfumes			
Cosmetic			
Wave sets			
Newspapers			
Wool			
Road dust			
Milk or milk products			
Eggs			
Wheat products			
Nuts, beans or seeds			
Chocolate			
Fish			
Meat			
Fruit			
Vegetables			
Alcoholic beverages			
Cheese, mushrooms			
Beer			
Wine			
Aspirin			
Chemicals (list)			
Drugs (list)			

	Yes	No	?
During what months do you usually have symptoms?			
All months			
January			
February			
March			
April			
May			
June			
July			
August			
September			
October			
November			
December			

Describe what symptoms bother you

When did your condition begin?

Do you use medication regularly for nasal symptoms? Yes No ?

What medication?

Does it help? Yes No ?

Do any of your blood relatives have allergies? Yes No ?

Have you ever had skin test for allergies? Yes No ?

Do you have allergies? Yes No ?

What are you allergic to?

Is there anything else about your problem which you think might be important or unusual?

	Yes	No	?
Do you have a history of:			
Migraine headaches			
Skin disease			
Heart disease			
Frequent headaches			
Sinus disease			
Stomach disease			
Asthma			
Nasal polyps			
Emphysema			
Broken nose			
Overactive thyroid			
Bronchitis			
Nasal surgery			
Underactive thyroid			
Hay fever			
Deviated septum			
Hormonal difficulty			
Hives			
Food allergy			
Drug allergy (describe):			
Other conditions (describe):			

Do you take any medication for any of the previous conditions? List:			
Do you think your occupation has anything to do with your symptoms? Describe:			
Describe your occupation:			

Any materials used in your occupation that may be something to do with your condition? Describe:			
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At work are your symptoms			
Better			
Worse			
The same			

Do you use a humidifier?			
Cold mist or steam?			
Do you have air conditioning?			
At work?			
At home?			
Central?			
Window unit in bedroom?			

	Yes	No	?
Do you spend a good deal of time in activities? List:			

Do you take any medications daily or frequently?			
Aspirin			
Cortisone			
Laxatives			
Sedatives			
Birth control pills			
Vitamins			
Ointments			
Nose drops/sprays			
Hormones			
Others?			
Specify:			

Smokers in your home?			
Do you smoke?			
Cigarettes # _____ per day			
Cigars # _____ per day			
Pipe # _____ per day			
Years smoked? _____			
Stopped smoking in year _____			

Do you have animals in your home? List:			
Have you ever had animals in your home? List:			

Do you live in:			
House?			
Apartment?			
In the city?			
In the suburbs?			

Is you dwelling:			
New?			
3-10 years old?			
11-25 years old?			
25+ years old?			

	Yes	No	?
Is your bedroom on:			
Lower floor			
Main floor			
Upper floor			
Wall to wall carpet?			
If so, age of carpet? _____			

Do you sleep with a pillow? Circle one				
Dacron	Foam	Rubber	Feather	

Is your mattress? Circle one				
Cotton	Feather	Foam rubber	Horse hair	
Other:				

Is your heating system? Circle one				
Oil	Gas	Electric	Wood stove	
Other:				

Is delivered by? Circle one			
Blower	Radiators	Electric panels	
Other:			

Filter? Circle one			
Fiberglass	HEPA	Permanent electrostatic	
How often cleaned or changed? _____			
Ducts cleaned?			
When?			
How often?			

Do you have a basement?			
Do you have a crawl space?			
Vapor barrier under house?			
Exhaust fan? Circle one			
Basement	Laundry	Kitchen	Bath

Is vacuum? Circle one			
Canister	Upright	Central	

Vacuum bag type? Circle one			
Permanent	Disposable	HEPA	water

Family room:			
Wall to wall carpet?			
If so, age of carpet? _____			
Hard surface in family room?			