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PATIENT ALLERGY QUESTIONAIRE

NAME:________________________________ DOB:_________ SEX:_________ DATE:________

CHIEF COMPLAINT: (please specify your symptoms)________________________________
____
____
____

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING:

NAME:	DOSE:	NAME:	DOSE:
___________________	____________	___________________	____________
___________________	____________	___________________	____________
___________________	____________	___________________	____________
___________________	____________	___________________	____________
___________________	____________	___________________	____________
___________________	____________	___________________	____________

1. ARE YOU ALLERGIC TO ANY MEDICATION?

________ ASPIRIN
________ PENICILLIN
________ OTHER MEDICATIONS_________________
Explain reaction:______________________
____
____

2. ARE YOU ALLERGIC TO THE FOLLOWING:

________ BEE OR WASP STING
________ FIRE ANT
________ FOOD (LIST) ______________________
________ LATEX

ALLERGY MEDICATIONS TRIED IN THE PAST: please list

_____________________________________ _____________________________________
_____________________________________ _____________________________________
_____________________________________ _____________________________________

PAST MEDICAL HISTORY

3. DO YOU HAVE OR HAVE HAD: WHEN?

______ NASAL ALLERGIES
______ ASTHMA
______ ECZEMA
______ HIGH BLOOD PRESSURE
______ DIABETES
______ THYROID DISEASE
______ ENLARGED PROSTATE
______ HEART DISEASE
______ REFLUX
______ LIVER DISEASE
______ KIDNEY DISEASE
______ GLAUCOMA
______ OSTEOPOROSIS
OTHER:_______________

HOSPITALIZATION HISTORY

4. HAVE YOU BEEN HOSPITALIZED: WHEN?

_____ ASTHMA
_____ PNEUMONIA
_____ ALLERGIC REACTIONS (ANAPHYLAXIS)
OTHER:_____________________________________
____
____
____

5. SURGICAL HISTORY (list all surgeries you have had and when)

______ SINUS SURGERY
______ EAR TUBES
______ TONSIL REMOVAL
______ ADENOID REMOVAL
______ NASAL POLYP REMOVAL
______ OTHER______________________

6. DID YOU EVER HAVE ALLERGY TESTING?

____

WHEN:____

7. DID YOU RECEIVE ALLERGY SHOT TREATMENT?

____
____
____

FAMILY HISTORY

8. ANY ONE IN YOUR FAMILY HAVE: (CHECK ALL THAT APPLY)

______ ASTHMA WHO:____________________
______ ALLERGIES WHO:____________________
______ FOOD ALLERGIES WHO:____________________
______ SWELLING WHO:____________________

9. SMOKING STATUS

______ NEVER SMOKED
______ CURRENT SMOKER
______ PREVIOUS SMOKER
______ OTHER SMOKERS IN THE HOUSEHOLD

ENVIRONMENTAL HISTORY

10. TYPE OF HOME:

______ HOUSE
______ APARTMENT
______ OTHER______________________

11. TYPE OF BEDROOM FLOORING:

______ TILE
______ WOOD
______ CARPET
______ AREA RUGS
______ OTHER______________________

12. BEDDING: (YES/NO)

______ DUST MITE COVERS
______ DRAPES/CURTAINS
______ FEATHER PILLOWS

13. AIR CONDITIONING:

______ CENTRAL
______ WINDOW UNIT
______

14. DOES YOUR HOME HAVE OR HAD ANY WATER LEAKS?

____

15. DO YOU HAVE ANY PETS? (check all that apply)

______ CATS ______ INSIDE ______ OUTSIDE
______ DOGS ______ INSIDE ______ OUTSIDE
______ BIRDS ______ INSIDE ______ OUTSIDE
______ HORSE ______ INSIDE ______ OUTSIDE
______ OTHER ________________________________