NEW PATIENT ALLERGY QUESTIONNAIRE

Information provided by this questionnaire will be of major assistance to the doctor in helping you. Please take the time to complete this questionnaire (it takes only 10-15 minutes) before your appointment. Base your answers on your own observations and not what you have been told by others or what you may have presumed based on the basis of previous allergy tests.

Gender:  □ Male  □ Female

Patient Name:____________________________________  Date:____________________

Home Address:____________________________________  Date of Birth:______________

City, State, Zip:____________________________________

Work #:_________________    Home #________________  Cell/Pager# _______________

Primary Care Physician_____________________________

Referring Physician________________________________

Insurance________________________________________

I. Major Reason for Referral

□ Hayfever or "sinus"
□ Insect sting reaction
□ Eye problems
□ Drug reaction
□ Asthma or chronic cough
□ Intestinal problem

□ Hives or swelling
□ Food allergy
□ Eczema or other rash
□ Recurrent infections
□ Headaches
□ Other_______________________________

II. Please describe in your own words the problem(s) that you are having which you think might be on a basis of an allergic reaction.

____________________________________________________________________________________________________

____________________________________________________________________________________________________

____________________________________________________________________________________________________

____________________________________________________________________________________________________

____________________________________________________________________________________________________
III. Symptom History
A. How long have you had your symptoms?__________________________________________

B. Are they getting worse? □ Yes □ No

C. Are your symptoms (check one):

□ Present all year but worse at certain times of the year?
□ Coming and going without apparent relation to the time of the year?
□ Only at certain times of the year?

D. Circle the months you are worse:

JAN FEB MAR APR MAY JUN JUL AUG SEP OCT NOV DEC

E. Do you have to miss school or work because of allergy symptoms?

□ No
□ Occasionally
□ Frequently

F. Do your symptoms disturb your sleep?

□ No
□ Occasionally
□ Frequently

G. Are you worse (circle): indoors, outdoors, at home, at work, mornings, or evenings

IV. Symptom Review (circle all appropriate answers)
A. Eye Symptoms: none, itching, watering, redness, swelling, crusting, dryness, burning, dark circles, blurred vision, wear contact lenses, other___________________________

B. Ear Symptoms: none, itching, popping, congested, frequent infections, fluid in middle ear, PE tubes, hearing loss, earache, dizziness, other_____________________________

C. Nasal Symptoms: none, sneezing, itching, sniffles, watery discharge, cloudy discharge, congestion, frequent nosebleeds, broken nose, loss of sense of smell/taste, polyps, frequent sinus infections, nasal dryness, snoring at night, other________________________

D. Mouth and throat symptoms: none, frequent sore throats, hoarseness, itchy throat, difficulty swallowing, swollen neck glands, mouth breathing, frequent strep throat, frequent tonsillitis, postnasal drip, other____________________________

E. Headaches: infrequent, occasional, frequent, occur with sinus symptoms, sharp, dull, pounding, facial, forehead, temples, back of head, migraine, other___________________________

F. Chest symptoms: none, chronic cough, chest tightness/congestion, wheezing, shortness of breath, wheeze/cough after exercise, sputum production, chest pain or soreness

Has asthma been previously diagnosed? □ Yes □ No

Frequent pneumonias? □ Yes □ No

Abnormal chest x-ray? □ Yes □ No □ have not had chest x-ray

Other_________________________________________________________________________
G. Stomach/Intestinal symptoms: none, nausea and vomiting, bloating, loss of appetite, abdominal pain or cramping, diarrhea frequently, constipation frequently, pain, or difficulty swallowing, heartburn or indigestion, other ________________

H. Skin symptoms: none, dry skin, hives, swelling, itchy skin, eczema, poison ivy/oak allergy, skin sensitivity to metals, chemicals, cosmetics, other ___________________________________________________________________________________

I. Insect sting reaction: none, large swelling, hives, difficulty breathing, throat swelling, dizzy, other ________________
Stung by: bee, fire ant, other ___________________________________________________________________________

V. Allergy Symptom Triggers
Which of the following do you think cause or make your symptoms worse. Please check appropriate boxes.

<table>
<thead>
<tr>
<th>Trigger</th>
<th>Nose/Sinus Eyes/Ears Symptoms</th>
<th>Asthma/ Bronchitis Symptoms</th>
<th>Hives/ Eczema Symptoms</th>
<th>Stomach/ Intestinal Symptoms</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>parks/fields</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>mowed grass</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>gardening</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>house dust</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>weather changes</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>windy days</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>humid days</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>hot days</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>cold days</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>air conditioning</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>forced air/heat</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>drafts</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>tobacco smoke</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>fumes/aerosols/sprays</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>cosmetics/perfumes</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>chemicals</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>soap powder</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>newspaper print</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>pets/animal exposure</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(list</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>exercise</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>tension/excitement</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>clothing/fabrics</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>medicines (which)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>milk/dairy products</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>beer/wines</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>certain foods</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(list below)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>menstrual periods</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>other(s)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Comments/explanation: ____________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________

VI. Treatment
A. List medications you have used to treat allergy symptoms (circle those that were helpful):
_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________
B. Side effects from medications: none, drowsiness, irritation or nervousness, insomnia, other__________

C. Do you use over-the-counter nasal sprays or drops? □ Yes □ No
If yes, how often?________________________________________________________________________________________

D. Have you taken cortisone (by injection or mouth) in the past two years? □ Yes □ No

E. Have you been on any special allergy diets? □ Yes □ No

F. Have you been tested for allergy previously? □ Yes □ No
If yes, when and where__________________________________________________________________________________

Did you have positive reactions to: (circle) pollen, dust, animal danders, molds, foods, other__________, no reactions.

G. Have you been on allergy shots before? □ Yes □ No
If yes, when, where, and for how long?________________________________________________________________________________________________________________________________________

Were they helpful? □ Yes □ No □ Not sure

H. Did you have a serious reaction to allergy testing or allergy shots? □ Yes □ No

VII. Past Medical History

A. Have you had an allergic reaction to any medications? □ Yes □ No
If yes, please list________________________________________________________________________________________

B. Please list medications (other than allergy medicines) that you take regularly:________________________________________________________________________________________

C. Previous hospitalizations for allergy problems? □ Yes □ No
If yes, please list________________________________________________________________________________________

D. Surgery that you had (circle): none, tonsillectomy, adenoidectomy, nasal septum repair, sinus surgery, tubes in ears, removal of nasal polyps, chest surgery.

E. Infancy-Early childhood problems (circle) none, milk allergy, formula changes, food allergy, colic, frequent diarrhea, frequent constipation, vomiting, frequent skin rashes, bronchiolitis, frequent bronchitis, asthma, eczema.

F. If patient is a child, has growth and development been normal? □ Yes □ No

G. Immunizations: severe or unusual reactions? □ Yes □ No

VIII. Review of Systems

A. Would you describe your general health as : excellent, good, fair, poor.

B. Other medical problems (circle): none, high blood pressure, heart disease, diabetes, emphysema, anemia, liver disease, jaundice, arthritis, intestinal disorders, TB, kidney disease, migraine, epilepsy (seizures), attention deficit disorder, cancer,
prostate trouble, thyroid trouble, glaucoma, fatigue, ulcers, sleep difficulty, frequent depression, irritability, other ____________________________________

C. Psychological Factors

- nervous tension: □ little □ considerable
- financial problems: □ minor □ major
- work or school adjustment: □ easy □ difficult
- marital adjustment: □ easy □ difficult

D. Smoking History □ Yes □ No

- If yes, amount ___________________________ how long_____________________________________
- When did you quit?____________________________________________________________________

E. Women of childbearing age: Are you pregnant, trying to conceive, or nursing a baby? □ Yes □ No

IX. Family History

A. Which family members (including grandparents, aunts, uncles) have hayfever or "sinus"?

__________________________________________________________

Which have asthma?________________________________________________________________________

Do any family members have (circle): hives or swelling, eczema, food allergy, drug allergy, insect allergy, emphysema, cystic fibrosis, TB diabetes, serious infections, death in infancy.

X. Environmental Survey

A. Residence

1. How long have you lived in Central Texas?_______________________________________________

2. Other areas of residence and dates:

_____________________________________________________________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________

3. Do you live in a (circle): house, apartment, mobile home, other____________________________

- Age of home________________________ How long at present address________________________

4. Home located in or near (circle): residential area, open fields, factory, lakes

5. What type of grasses, trees, and shrubs are in your neighborhood?________________________

_____________________________________________________________________________________

6. Is your home air conditioned? □ Yes □ No if yes, central or window? Fans? □ Yes □ No

7. Is your home heated? (circle) central, wall, space heaters, fireplace
8. Do you have pets at home? □ Yes □ No
if yes, (circle) dog, cat, birds, hamsters, other ____________________________________________

Do the pets spend time indoors? □ Yes □ No □ N/A

In the bedroom? □ Yes □ No □ N/A
List other pets you are exposed to regularly ________________________________________________
How long have you had pets? ____________________________________________________________

9. Are there smokers at home? □ Yes □ No □ N/A
If yes, how many? ____________________

10. In patient's bedroom, are there (circle): plants, stuffed toys, carpet, rugs, down comforters, pillows, (feather, foam or synthetic?), drapes, blinds, bookshelves, bunkbeds, humidifiers/vaporizers.

B. Occupation/Hobbies
1. Current occupation: ________________________________________________________________
If patient is a child, parents' occupation(s) ______________________________________________

2. Previous occupation(s): __________________________________________________________

3. Are you exposed to anything at work or school that might aggravate your condition? □ Yes □ No
If yes, what ________________________________________________________________

4. Hobbies (circle): sewing, gardening, cooking, painting, sports, photography, other _____________
__________________________________________________________________________________

5. If patient is a child, is he or she in daycare? □ Yes □ No

Thank you very much for taking the time to fill out this questionnaire. The doctor will review this questionnaire before seeing you.