AUSTIN REGIONAL CLINIC

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 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.

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

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,

prostrate 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 your are exposed to regularly _____

How long have you had pets?_____

9. Are there smokers at home? ☐ Yes ☐ No 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.