Date____________________

Schreiber Allergy

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ALLERGY QUESTIONNAIRE

Please complete as carefully as possible. All information is confidential and will help us determine what is causing your symptoms.

Patient Name____
Street Address______________________________________
City______________________State ______Zip Code_________
Cell Phone____
Home Phone ____
Work Phone____
Occupation ____
Place of Employment _________________________________

Email____
Patient Birthdate____________________ Age_____________
Gender Male □ Female □ ________________ □
Married □ Single □ Other □
Referred By____
Pediatrician/Family Practitioner________________________
Do we see your family member(s)? Yes □ No □
Name(s)____

For PEDIATRIC Patients:
Parent's Name ______________Occupation_________________
Parent's Name ______________Occupation_________________

For ADULT Patients:
Spouse's Name ______________Occupation_________________
Employer___________________ Work Phone________________

The reason for your visit today: ____
____

MEDICAL HISTORY:

Please list any **chronic medical conditions/past illnesses**: ______________________________________
____

Please list any known **food/drug allergies** and associated **reactions**:______________________________
____

For PEDIATRIC Patients:
Full Term Pregnancy: Yes □ No □ ______________________
Complicated Pregnancy: Yes □ No □ ______________________
C-section Delivery: Yes □ No □
Birth Weight:________lbs________oz
Breast Feeding: Yes □ No □ ….. to age____________
Bottle Feeding: Yes □ No □ ….. to age____________

Feedings Tolerated Well: Yes □ No □
Whole Milk: Yes □ No □ began at age_______
Immunizations up to date: Yes □ No □
Parents of patient are: Married □ Separated □ Divorced □
Primary residence is: One home □ Split between homes □

SURGICAL HISTORY:

Please list any **surgeries**:____
____

BIRTH FAMILY HISTORY:

	Alive & Well	Seasonal Allergies	Asthma	Eczema	Hives	Drug Allergy	Food Allergy	
Father	☐	☐	☐	☐	☐	☐	☐	______________________
Mother	☐	☐	☐	☐	☐	☐	☐	______________________
Brother	☐	☐	☐	☐	☐	☐	☐	______________________
Sister	☐	☐	☐	☐	☐	☐	☐	______________________
Daughter	☐	☐	☐	☐	☐	☐	☐	______________________
Son	☐	☐	☐	☐	☐	☐	☐	______________________
M. Grandfather	☐	☐	☐	☐	☐	☐	☐	______________________
M. Grandmother	☐	☐	☐	☐	☐	☐	☐	______________________
P. Grandfather	☐	☐	☐	☐	☐	☐	☐	______________________
P. Grandmother	☐	☐	☐	☐	☐	☐	☐	______________________
Other __________	☐	☐	☐	☐	☐	☐	☐	______________________

Please list any other chronic condition (e.g. cystic fibrosis, emphysema, recurrent hives or swelling, lupus, rheumatoid arthritis, etc) along with the corresponding family member:____

CURRENT ENVIRONMENT:

	Yes	No	
Personal History of Smoking	☐	☐	______________________________
Tobacco Exposure	☐	☐	______________________________
Pets (how many? type?)	☐	☐	______________________________
Carpeting	☐	☐	______________________________
Damp Basement	☐	☐	______________________________
Houseplants	☐	☐	______________________________
Air Cleaner	☐	☐	______________________________
Central A/C	☐	☐	______________________________
Forced Air Heat	☐	☐	______________________________
Down Comforter	☐	☐	______________________________
Feather Pillow	☐	☐	______________________________
Stuffed Animals	☐	☐	______________________________

Last **Flu Shot** (approx. date):____________________________

SYMPTOMS ARE MADE WORSE BY:

☐ Colds ☐ Foods
☐ Cigarette Smoke ☐ Cats
☐ Mowing Grass ☐ Dogs
☐ Raking Leaves ☐ Heat
☐ Perfumes or Scents ☐ Cold
☐ Dusting/Cleaning ☐ Other ____________________

THESE SYMPTOMS OCCUR:

☐ Spring ☐ Summer ☐ Fall ☐ Winter
☐ Days or weeks at a time ☐ All the time
☐ At home Room ___________________
☐ Worse outside ☐ At work ☐ At school
☐ All day ☐ Worse at night or morning

Transfer of allergy care from Dr. __________________________

Continuation of allergy shorts started _____________years ago

Diagnosis of asthma was made __________________years ago

Number of past hospitalizations for asthma________________

Days of school/work missed in past year___________________

Number of ear infections in the past year__________________

Number of sinus infections in the past year_________________

Number of pneumonias during lifetime____________________

LABORATORY TESTS:

	Where Done	Date	Normal	Abnormal
Chest / Sinus X-ray			☐	☐
Sweat Test			☐	☐
TB Skin Test			☐	☐
Allergy Skin Test			☐	☐

MEDICATION INFORMATION:

Pharmacy name and location:____

Medication Name	Dosage	Frequency Per Day
___________________________________	_______	_________________
___________________________________	_______	_________________
___________________________________	_______	_________________
___________________________________	_______	_________________
___________________________________	_______	_________________
___________________________________	_______	_________________
___________________________________	_______	_________________
___________________________________	_______	_________________

REVIEW OF SYSTEMS:

	Yes	**No**	
Fever	☐	☐	____________________
Recent weight loss	☐	☐	____________________
Itchy eyes	☐	☐	____________________
Excessive tearing	☐	☐	____________________
Nasal Congestion	☐	☐	____________________
Runny Nose (rhinorrhea)	☐	☐	____________________
Sneezing	☐	☐	____________________
Snoring	☐	☐	____________________
Post-nasal Drip	☐	☐	____________________
Heart problems	☐	☐	____________________
Cough, productive (wet)	☐	☐	____________________
Cough, non-productive (dry)	☐	☐	____________________
Wheezing	☐	☐	____________________
Heartburn/indigestion	☐	☐	____________________
Other abdominal pain	☐	☐	____________________
Nausea/vomiting	☐	☐	____________________
Diarrhea	☐	☐	____________________
Urinary or bladder problems	☐	☐	____________________
Joint swelling or pain	☐	☐	____________________
Skin rash	☐	☐	____________________
Eczema	☐	☐	____________________
Hives (urticaria)	☐	☐	____________________
Nerve problems	☐	☐	____________________
Psychiatric problems	☐	☐	____________________
Hormone problems/hot flashes	☐	☐	____________________
Easy bruising/bleeding	☐	☐	____________________
Blood count problems (anemia, etc)	☐	☐	____________________
Severe/recurrent infections	☐	☐	____________________