The Center for
ALLERGY & SINUS

Allergy History Questionnaire

Please complete this allergy history questionnaire and bring to your appointment. Please answer all questions.

Patient Name _____ Date of Birth _____

Referring Physician _____ How did you hear about us? _____

What allergy-type symptom made you want to seek treatment? _____

_____

Seasonal Incidence - please check applicable seasons/symptoms

	Spring	Summer	Fall	Winter
Wheezing	_____	_____	_____	_____
Coughing	_____	_____	_____	_____
Nasal	_____	_____	_____	_____
Eye	_____	_____	_____	_____
Hives	_____	_____	_____	_____
Eczema	_____	_____	_____	_____
Other _____	_____	_____	_____	_____

Previous Treatment / Testing

Prior allergy testing? ☐ Yes ☐ No

Have you received allergy shots/drops before? ☐ Yes ☐ No

If yes, how long & did it help? _____ ☐ Yes ☐ No

Medications you have tried, over-the-counter and/or prescription, and have discontinued:

☐ Nasal sprays ☐ Pills/tablets/etc. ☐ Inhalers ☐ Eye or ear drops

How many times a year were you treated with antibiotics for nasal/sinus infections?

☐ 1 - 2 ☐ 3 - 4 ☐ 5 or more

When was the last date you were treated with antibiotics? _____

Have you had sinus imaging / CT scan? ☐ Yes ☐ No Date _____

Ears

Itching	☐ Yes	☐ No
Fullness	☐ Yes	☐ No
Popping	☐ Yes	☐ No
Tubes placed	☐ Yes	☐ No
Hard of hearing	☐ Yes	☐ No
Infections	☐ Yes	☐ No

Throat

Soreness	☐ Yes	☐ No
Post-nasal drip	☐ Yes	☐ No
Itching of palate	☐ Yes	☐ No
Recurrent strep	☐ Yes	☐ No
Tonsils removed	☐ Yes	☐ No
Adenoids removed	☐ Yes	☐ No

Nose

Sneezing	☐ Yes	☐ No
Watery discharge	☐ Yes	☐ No
Congestion	☐ Yes	☐ No
Itching	☐ Yes	☐ No
Nasal trauma	☐ Yes	☐ No
Bloody nose	☐ Yes	☐ No
Loss of smell	☐ Yes	☐ No
Sinus surgery	☐ Yes	☐ No
Mouth breathing	☐ Yes	☐ No
Bad breath	☐ Yes	☐ No
Snoring	☐ Yes	☐ No
Sinusitis	☐ Yes	☐ No

Eyes

Contact lenses	☐ Yes	☐ No
Glasses	☐ Yes	☐ No
Itching	☐ Yes	☐ No
Burning	☐ Yes	☐ No
Watering	☐ Yes	☐ No
Swelling	☐ Yes	☐ No
Redness	☐ Yes	☐ No
Discharge	☐ Yes	☐ No
Glaucoma	☐ Yes	☐ No
Cataracts	☐ Yes	☐ No

Chest

Cough	☐ Yes	☐ No
Wheezing	☐ Yes	☐ No
History of bronchitis	☐ Yes	☐ No
History of pneumonia	☐ Yes	☐ No
Shortness of Breath	☐ Yes	☐ No
At rest	☐ Yes	☐ No
Exercising	☐ Yes	☐ No
Coughed up blood	☐ Yes	☐ No
Positive TB skin test	☐ Yes	☐ No
Smoker	☐ Yes	☐ No
Currently	☐ Yes	☐ No

Material _____
How long _____
Amount _____
If no, quit date _____

Pulmonary function test ☐ Yes ☐ No Date _____

Skin

Eczema	☐ Yes	☐ No
Rashes	☐ Yes	☐ No
Hives	☐ Yes	☐ No
Swelling	☐ Yes	☐ No
Infections	☐ Yes	☐ No
Latex sensitivity	☐ Yes	☐ No

Insect Stings

Local swelling	☐ Yes	☐ No
Tongue / lip swelling	☐ Yes	☐ No
Scattered hives	☐ Yes	☐ No
Shortness of breath	☐ Yes	☐ No
Caused ER visit	☐ Yes	☐ No

Have you or do you currently work in any industrial exposure? ☐ Yes ☐ No

If yes, give example(s) _____

Do you have problems with food ingestants? For instance: swelling, itching of tongue lips or mouth, rash or hives, immediate or delayed vomiting or diarrhea. Please note item and reaction. _____

Have you had any problems, such as an allergic/adverse reaction, with a medication?

Medication	Reaction

Current Medications

Medication	Frequency	For what condition

Have you experienced any of the following?

High blood pressure	☐ Yes	☐ No	Diabetes	☐ Yes	☐ No
Heart disease / arrhythmia	☐ Yes	☐ No	Thyroid disease	☐ Yes	☐ No
Blood transfusions	☐ Yes	☐ No	Liver disease	☐ Yes	☐ No
Uncontrolled bleeding	☐ Yes	☐ No	Kidney disease	☐ Yes	☐ No
Dental problems	☐ Yes	☐ No	Arthritis	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Heartburn	☐ Yes	☐ No
Childhood chicken pox	☐ Yes	☐ No	Chronic Diarrhea	☐ Yes	☐ No
Surgeries	☐ Yes	☐ No			

If yes, when and why? _____

_____

Hospitalizations in the last 5 years ☐ Yes ☐ No

If yes, when and why? _____

_____

Family History

Mother's age _____ Father's age _____

Number of brothers _____ Number of sisters _____

Number of children and ages _____

Does anyone in your family have

Allergies	☐ Yes	☐ No	Diabetes	☐ Yes	☐ No
Inhalants	☐ Yes	☐ No	Thyroid disease	☐ Yes	☐ No
Food	☐ Yes	☐ No	Rheumatoid arthritis	☐ Yes	☐ No
Insect	☐ Yes	☐ No	Lupus	☐ Yes	☐ No
Drug	☐ Yes	☐ No	Leukemia/lymphomas	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Hives	☐ Yes	☐ No
Cystic Fibrosis	☐ Yes	☐ No	Eczema	☐ Yes	☐ No
Lung cancer	☐ Yes	☐ No	Sickle cell disease	☐ Yes	☐ No
Sarcoidosis	☐ Yes	☐ No	Sickle cell carrier	☐ Yes	☐ No
Tuberculosis	☐ Yes	☐ No	Hypertension	☐ Yes	☐ No
Stroke(s)	☐ Yes	☐ No	Heart disease	☐ Yes	☐ No

Social History

Occupation _____

Alcohol consumption ☐ Yes ☐ No

Type _____ Frequency _____

Anyone in the home smoke? ☐ Yes ☐ No

Material _____ Frequency _____

Caffeine consumption ☐ Yes ☐ No

How much _____ Frequency _____

Travel outside of South Central U.S. ☐ Yes ☐ No

Hobbies _____

_____

Environment

How long have you lived in Texas? _____

Previous state(s)? _____

Location of home ☐ Country ☐ Suburb ☐ City

Type of home ☐ Apartment ☐ Frame ☐ Brick

Heating / cooling system ☐ Central AC ☐ Window unit ☐ Neither

How old is your dwelling? _____ How long have you lived there? _____

Do you have plants in your bedroom? ☐ Yes ☐ No

Animals

Do you have any pets? ☐ Yes ☐ No What kind (species)? _____

How long have these pets been with you? _____

Does the animal have full range of the house? ☐ Yes ☐ No

Does the animal sleep in your bedroom? ☐ Yes ☐ No

Does exposure to the animal make symptoms worse? ☐ Yes ☐ No

Please complete this form PRIOR to your appointment and bring with you to the appointment for review.