Allergy Intake Questionnaire

Patient name: ___________________________________ DOB: _________ Today’s Date: __________

1. PATIENT HISTORY
   a. When did your allergy symptoms begin (please mark one):
      
      Infancy ____  Childhood ____  Teens ____  Age ____  or Year ____
   b. How long have you lived in the area? _____________
   c. Do you plan to stay in the area? _____________
   d. What areas are most affected by your allergies (circle all that apply):
      
      Eyes     Ears     Nose     Throat     Lungs     Skin     GI Symptoms
   Please describe what symptoms you experience that are most bothersome: __________
      __________________________________________________________________________

2. ALLERGIC HISTORY
   a. Have you been diagnosed or treated for eczema? If so, what treatment? _______________
   b. Have you been diagnosed or treated for asthma? If so, what treatment? _______________
   c. Do you have any of these symptoms (circle all that apply)?
      
      Wheezing    Nighttime cough    Restricted breathing    Shortness of breath    Itchy Skin
   d. Do you have any food allergies? If so, what? ______________________________________
   e. Do you have venom allergies or latex allergies?    Yes    No

3. ENVIRONMENTAL EXPOSURES
   a. What exacerbates your symptoms (circle all that apply)?
      
      Outdoors    Indoors    At home    At work    Animals
   b. Are there environmental exposures that tend to exacerbate your symptoms (ie. Perfumes, air conditioning etc.)? __________________________________________________________________
   c. What season are your symptoms worst? (circle all that apply)
      
      Spring    Summer    Fall    Winter
   d. What type of flooring do you have (ie. Carpet, hardwoods, etc.)? ____________________________
Patient name: ___________________________________  Date: _______________

e. What type of pillow, comforter, or mattress do you use (ie. Feather, down, etc.)?
___________________________________________________________________________

f. Do you have HEPA filters or an air filtration system?  Yes            No

g. Do you have air conditioning and if so what type? __________________________________

h. Do you have vapor barrier under your house?  Yes            No            Unsure

i. Do you have animals in your home (or regular exposure), and if so, what type? ___________

j. Where do you live? (Circle all that apply)
   Home           Apartment           Rural           Suburban           Urban

4. MEDICATION HISTORY
a. What medications have you used in the past for your allergies?
   Name: ___________________  Did it work? _______  How long did you use it? ______________
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5. FAMILY HISTORY
a. Does anyone in your immediate family have allergies, asthma, or eczema? ______________

   b. Has anyone undergone allergy testing or immunotherapy? ______________________________

6. IMMUNOTHERAPY HISTORY
a. Have you ever had an anaphylactic reaction?  Yes            No            Unsure

   b. Have you ever had allergy shots, drops or tablets?  Yes            No            Unsure

      If so, when, where, and for how long? _______________________________________________