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ALLERGY SURVEY SHEET

App't Date: _____
App't Time: _____

air ALLERGY ASTHMA IMMUNOLOGY OF ROCHESTER PC

This questionnaire is lengthy for obvious reasons. It will give a clear picture of the allergic aspects of the patient's suffering. Remember that when such a history is taken, it involves planning to embark on a long treatment program. Such a program cannot be started without a meticulous history.

Date of answering this questionnaire _____

Answered by: Patient Other _____

PERSONAL DATA

Name _____ Age _____

Birth date _____ Birth place _____ Sex _____

Address _____

Home phone _____ Work phone _____

Marital status: ☐ Single ☐ Married ☐ Widow ☐ Divorced ☐ Separated

Health Insurance _____

Referred by _____

Family doctor _____

Other doctors consulted _____

List the areas where you have lived, in chronological order, giving dates:

Area	From What Date	To What Date

Employer's name _____

Type of work _____

What is the highest level of education you have reached? _____

List your past occupations chronologically giving dates:

Occupation	From What Date	To What Date

Hobby (What do you do in your spare time?) _____

Past hobbies _____

Hobbies of other family members living with you _____

HABITS

Do you smoke? ☐ Cigarettes ☐ Pipe-How many a day? _____

For how many years? _____ Did you formerly smoke? _____

When did you quit? _____

Alcohol: What do you drink? _____

How many drinks a day/week? _____

Have you ever been treated for alcoholism? _____

Exercise: How often? _____ What kind? _____

Sleep: Do you sleep well? _____ How many hours a day? _____

Diet: Are you on a diet? _____ What kind? _____

Psychological factors: Financial problems- ☐ Major ☐ Average ☐ Little

Nervous tension - ☐ Major ☐ Little

Work school adjustment - ☐ Difficult ☐ Easy

Marital adjustment - ☐ Difficult ☐ Easy

Reasons for nervous tension, if any _____

CHIEF COMPLAINT (What led you to consult an allergist)

	Problem (No. 1 = most important)	Date of Onset
1		
2		
3		
4		

REVIEW OF ALLERGY HISTORY

I. *Early Childhood* (check the applicable)

☐ Colic in infancy ☐ Eczema in childhood ☐ Feeding problem (milk, eggs, etc.) ☐ Frequent ear infections ☐ Frequent colds ☐ Bronchitis or wheezing

II. *Nasal Symptoms* - If present

Age of onset of earliest nasal symptoms _____

Description of symptoms ☐ Nasal blockage ☐ Nasal congestion ☐ Sneezing ☐ Sniffling ☐ Itchy nose ☐ Runny nose

Color of drainage ☐ Clear ☐ White ☐ Yellow ☐ Green

Post-nasal drainage - ☐ Constant ☐ Periodic ☐ Occassionally ☐ Never a problem

Clearing of throat - ☐ Frequent ☐ Occassional ☐ Nasal speech ☐ Loss of taste ☐ Loss of smell ☐ Nose bleeds ☐ Sinus headaches accompanying nasal symptoms

Have you ever been told that you had or had treatment for the following:

☐ Nasal polyps ☐ Deviated nasal septum ☐ Nasal or sinus surgery or washing ☐ Broken nose ☐ Sinus infections ☐ Sinus x-ray (when)

WHICH OF THE FOLLOWING AGGRAVATES YOUR NASAL OR SINUS SYMPTOMS:

1. Antigens - ☐ Exposure to house dust: ☐ Sweeping ☐ Dusting ☐ Housecleaning

☐ Worse in morning ☐ Worse at night ☐ Worse when furnace on

☐ Exposure to pollens: ☐ Lawnmowing ☐ Auto rides ☐ Golf ☐ Playing on grass ☐ Working in garden ☐ Pulling weeds

☐ Exposure to musty moldy areas: ☐ Hay Barn ☐ Circuses ☐ Damp basements ☐ Raking leaves ☐ Eating cheese ☐ Mushrooms ☐ Beer ☐ Wine Problem worse ☐ outdoors ☐ indoors

Seasonal occurrences: ☐ All year ☐ Early spring (Mar.-Apr.) ☐ Late spring (May-June) ☐ Summer (July-Sept.) ☐ Fall (Oct.-Nov.) ☐ Winter (Dec.-Feb.)

Foods (specify which foods aggravate nasal symptoms) _____

Animal contact (specify which animals aggravate symptoms) _____

Vacation: Where worse: _____ Where better: _____

Location: Where worse (home, work, farm, school, church, etc.) _____ Where better _____

2. Irritant Exposure - ☐ Tobacco smoke ☐ Other smoke ☐ Strong odors ☐ Perfumes ☐ Cosmetics ☐ Paint ☐ Varnish ☐ Insecticides ☐ Smog ☐ Fumes ☐ Newsprint ☐ Other _____

3. Weather Changes - ☐ Heat ☐ Cold ☐ Rain ☐ Humidity ☐ Barometric pressure ☐ Drafts ☐ Wind ☐ Air conditioning

4. Infections - ☐ Head colds: How many a year? _____

How long does each cold last? _____

5. Emotional upsets: Aggravate nasal symptoms? _____

6. Pregnancy: Aggravate or lesson symptoms? _____

7. Medications (which one aggravates nasal symptoms) - ☐ Aspirin ☐ Birth control pills ☐ Hormone pills ☐ Blood pressure pills

Other _____

8. Associated Hay Fever Symptoms: ☐ Ears itch or pop ☐ Fatigue ☐ Hearing loss ☐ Ear drainage ☐ Itchy throat ☐ Low "pep" ☐ Ear infections

III. *Eye Symptoms*

Age of onset of earliest symptoms _____

Desription - ☐ Redness ☐ Itchy ☐ Watery ☐ Mattering ☐ Puffiness around eyes ☐ Bluish around eyes

Are symptoms - ☐ All year ☐ Spring ☐ Fall ☐ Winter ☐ Summer

What aggravates eye symptoms? _____

Are eye symptoms worse when nasal symptoms are bad? _____

IV. *Chest Symptoms*

Age of onset of earliest chest symptoms _____

Date of first attack _____

Place, time and mode of onset _____

Description of symptoms ☐ Difficulty in breathing ☐ Shortness of breath ☐ Chest tightness ☐ Wheezing ☐ Chest pain

Cough ☐ How long?____ ☐ Daily ☐ Periodic ☐ Night ☐ Daytime

Phlegm ☐ Yes ☐ No Amount of sputum per day ☐ 1 teaspoon ☐ 1 tablespoon ☐ 1 cup ☐ More than a cup

Color of phlegm ☐ Clear ☐ White-Grey ☐ Yellow ☐ Green ☐ Brown ☐ Black ☐ Blood tinged

Severity of chest symptoms - frequency of chest symptoms: ☐ Daily ☐ Weekly ☐ Monthly ☐ Periodic How many attacks of difficulty breathing in last one year? _____

How long does each attack last? ☐ Minutes to hours ☐ Days ☐ Weeks ☐ Months

Approximate number of school/work days missed per year due to chest symptoms: _____

Do you have trouble sleeping because of chest symptoms? ☐ Yes ☐ No

Do you awake in the night short of breath or wheezing? _____

If adrenalin shots given for chest symptoms, list dates _____

List emergency visits for chest symptoms, if any _____

List hospitalization for chest symptoms, with name of hospital and date

_____

_____

In the last five years, the chest symptoms have been getting ☐ Better ☐ Worse ☐ Same

WHICH OF THE FOLLOWING AGGRAVATES YOUR CHEST SYMPTOMS:

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☐ Worse in morning ☐ Worse at night ☐ Worse when furnace on

☐ Exposure to pollens: ☐ Lawnmowing ☐ Auto rides ☐ Golf ☐ Playing on grass ☐ Working in garden ☐ Pulling weeds

☐ Exposure to musty moldy areas: ☐ Hay Barn ☐ Circuses ☐ Damp basements ☐ Raking leaves ☐ Eating cheese ☐ Mushrooms ☐ Beer ☐ Wine Problem worse ☐ outdoors ☐ indoors

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3. Weather Changes - ☐ Heat ☐ Cold ☐ Rain ☐ Humidity ☐ Barometric pressure ☐ Drafts ☐ Wind ☐ Air conditioning

4. Exercise ☐ Wheezing during exercise ☐ Wheezing right after exercise ☐ Cannot exercise due to shortness of breath and wheezing

5. Emotional - ☐ Chest symptoms worse when emotionally upset ☐ Chest symptoms make you panicky

6. Infections - Chest symptoms start to get worse with the following:

☐ Sinus infections (yellow nasal drainage, sinus pain)

☐ Bronchitis (coughing yellow or green phlegm)

☐ Head colds (relapse of chest symptoms coincides or follows head colds)

☐ Do your colds tend to settle in your chest usually? ☐ Yes ☐ No

☐ Post-viral onset (flu like symptoms evolve into persistent cough, then chest difficulties).

Has there been pneumonia? ☐ Yes ☐ No When?_____

Has there been fever or chills with chest symptoms? ☐ Yes ☐ No

How many times?_____

7. Aspirin Intolerance Type - ☐ Chest symptoms worse after taking aspirin ☐ Yellow pills of any kind

8. Use of Inhalers - what inhaled medicines do you use for chest symptoms? _____

How many times a day? _____

9. Associated Diseases - Do you, or did you have any of the following:

☐ Pneumonia ☐ Pleurisy ☐ Chronic bronchitis ☐ Emphysema

☐ Family history of emphysema ☐ Tuberculosis ☐ Lung tumor

☐ Hiatal or esophagus hernia

Can you sleep flat on bed? ____ How many pillows do you use? _____

When was your last chest x-ray? _____

V. *Eczema*

Site of onset _____ Age of onset _____

Areas which have been involved _____

Area most commonly involved during past year _____

Areas now involved _____

Still present? ☐ Yes ☐ No Age of clearing _____

Have you ever had boils? ☐ Yes ☐ No. Have you ever had impetigo? ☐ Yes ☐ No List all known or suspected offenders that aggravate eczema _____

_____

VI. *Urticaria (Hives)*

Age of onset ☐ Frequency - ☐ Daily ☐ Weekly ☐ Monthly ☐ Periodic ☐ Constant. Location - ☐ Face ☐ Trunk ☐ Arms ☐ Legs ☐ Hands ☐ Feet Other _____

Associated Symptoms - ☐ Breathing trouble ☐ Choking ☐ Throat Swelling ☐ Lip Swelling ☐ Stomach pains ☐ Hay fever

Do you have dental problems? ☐ Yes ☐ No

List all known or suspected things that may cause your hives (including foods) _____

_____

VII. *Contact Allergy*

Do you have skin rashes after contact with ☐ Poison Ivy ☐ Poison Oak ☐ Poison Sumac ☐ Metals (Jewelry). When was last attack? _____

What treatment given? _____

List if any chemical, drug, ointments, etc., produce skin rash _____

List all names of soaps, laundry additives, etc. used _____

List bath oils, skin lotions, creams, etc., used _____

VIII. *Photosensitivity Reactions*

Do you break out after exposure to sunlight? ☐ Yes ☐ No

When was last attack? _____

What medicines were you on at that time? _____

IX. *Headaches*

Age of onset Type - ☐ Aching ☐ Throbbing ☐ Dull Pain ☐ Other

Where does head hurt? _____

Frequency - ☐ Daily ☐ Weekly ☐ Other _____

Is headache associated with ☐ Nausea ☐ Disturbance of vision ☐ Nasal or sinus symptoms

Are there any symptoms prior to onset of headache? ☐ Yes ☐ No

List symptoms _____

What medicines help? _____

What aggravates your headache? _____

X. *Insect Sensitivity*

Do you have any symptoms from the following insect sting or bite?

☐ Mosquito ☐ Bee ☐ Wasp ☐ Bumble bee Yellow jacket

☐ Hornet ☐ Flea Other _____

Description of symptoms - ☐ Mild swelling at site ☐ Moderate swelling at site ☐ Severe swelling at site ☐ Severe generalized swelling

☐ Hives ☐ Breathing trouble ☐ Other _____

List any treatment you have received for an insect sting (hospitalization, medicines, etc.) _____

XI. *Food Allergy*

Do any foods cause adverse reaction? ☐ Yes ☐ No. Which foods?

_____ What reaction? _____

If any special allergy diet was tried in the past, specify _____

Type of allergy diet _____ conclusions reached _____

XII. *Drug Allergy*

Penicillin: When last taken? _____ ☐ Injection ☐ Tablets

What type of adverse reaction? _____

What treatment given? _____

Aspirin: How often taken? ☐ Daily ☐ Weekly ☐ Seldom ☐ Time a week

List adverse reactions from aspirin _____

Other Drug	Last Taken	How much later Reaction Occured	Type of Reaction

XIII. *Medication History*

List medications used for allergy or any other conditions, including those taken orally, injected, or ointments for the skin. (Include vitamins, health foods, etc.)

	Medications Previously Used	What Color?	Date & How Often Used	Helped Yes	Helped No	Date Stopped Taking	Describe Any Ill Effects or Reactions
1							
2							
3							
4							
5							
6							

	Medications Currently Used	What Color?	Date & How Often Used	Helped Yes	Helped No	When Started Taking	Describe Any Ill Effects or Reactions
1							
2							
3							
4							
5							
6							

XIV. *Immunizations*

Please give the years when the following immunizations and tests were given:

DPT (Diphtheria, pertussis, tetanus)				Mumps			
Oral Polio				TB Test			
Smallpox				Histoplasmin			
Measles 1 (Rubeola)				Other			
2 (Rubella)							

Was TB Skin Test positive? ☐ Yes ☐ No Did you have adverse reaction to any immunization? _____

XV. *Family History*

Relation		If Living Age	If Living Health	If Deceased Age at Death	If Deceased Cause	Please list any allergy symptoms, asthma, hay fever, "sinus" trouble, hives, eczema, drug allergy, other
Father						
Mother						
Brothers	1					
	2					
	3					
	4					
Sisters	1					
	2					
	3					
	4					
Husband or Wife						
Sons	1					
	2					
	3					
	4					
Daughters	1					
	2					
	3					
	4					

List other blood relative (aunts, uncles, etc.) with allergies such as hay fever, asthma, hives, etc. Please put "M" if mother's side of family or "F" if father's side of the family. _____

XVI. *Environmental History*

Do you live in ☐ House? ☐ Apartment? ☐ Own ☐ Rent ☐ Rural ☐ City

Time lived at present home _____ How old is dwelling? _____

Check animals in your home:

Animal	Inside	Outside	Both	# of Years
Dog	☐	☐	☐	_____
Cat	☐	☐	☐	_____
Birds	☐	☐	☐	_____
Other Pets	☐	☐	☐	_____

If you live on a farm, are you exposed to: ☐ Chickens ☐ Horses ☐ Cattle ☐ Sheep ☐ Hogs ☐ Barns ☐ Grains ☐ Other

Home in General

Heating System - ☐ Forced air ☐ Wall heater ☐ Hot water ☐ Gas ☐ Electric ☐ Other

How often do you change or clean filter in heating system? _____

Air conditioner - ☐ None ☐ Room unit ☐ Central ☐ Humidifier ☐ Purifier ☐ Electrostatic air filter. When installed? _____

Has there been any recent painting in the home? ☐ Yes ☐ No

When? _____ What brand of paint/varnish? _____

How many indoor plants? _____ In which room? _____

How many in bedroom? _____

Is there an aquarium in the home? ☐ Yes ☐ No

In which room? _____

Are there damp, musty areas in the home? ☐ Yes ☐ No

Where? _____

Which family members living with you smoke? _____

Types of trees in your neighborhood _____

Types of grass, flowers or shrubs in your yard _____

Bedroom:

Pillows - ☐ Foam ☐ Feather or down ☐ Dacron ☐ Encased ☐ Other _____

Type of mattress - ☐ Regular ☐ Waterbed

How old? _____ ☐ Encased

☐ Feather comforter ☐ Wool blankets ☐ Stuffed toys. ☐ Carpets or Rugs ☐ Yes ☐ No Type ☐ Wool ☐ Nylon ☐ Shag

How is your bedroom cleaned? ☐ Vacuumed ☐ Swept ☐ Damp mopped ☐ Dry dusted ☐ Damp or spray dusted

How often? _____

Mention any unusual allergy exposure at work or home _____

XVII. *Previous Allergy Work Up*

Have you had allergy tests or treatment before? ☐ Yes ☐ No

When? _____

Where? _____

By whom? _____

Results of tests _____

Allergy shots given (dates) _____

Did allergy shots help? ☐ Yes ☐ No

Any adverse reaction to allergy shots? ☐ Yes ☐ No

What reaction? _____

List any other problems that you think are caused by allergy, not coverd above: _____

Diet: *List foods most likely eaten for:*

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

XVIII. *Past History*

List, in chronological order, hospitalizations for medical or surgical problems (do not include child birth unless general anesthesia as in Caesarean section)

Date	Nature of Problem

XVIV. *Review of Systems*

List any other ongoing health problems and medications used for them

Health Problem	Medications Used

Briefly, describe or list your child's present problems (symptoms, age of onset, frequency), and list questions and/or concerns. These will be discussed.