Allergy Patient Questionnaire

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Adult and Pediatric Allergy, Asthma and Clinical Immunology

Patient Name: _____ Occupation_____

Best Contact Phone Number: _____ Referred By: _____

Reason for Visit: _____

ALLERGY HISTORY (please check where appropriate):

Chest Symptom (asthma) ✓		**Nasal Symptom** (hay fever, sinus) ✓		**Skin** (Eczema) ✓	
Duration (years):		Duration (years):		Duration (years):	
Wheezing		Sneezing		Rash	
Coughing		Runny nose		Itching	
Chest tightness		Post-nasal drip		Location of rash:	
Emergency visits (last year):		Stuffy nose			
		Itchy: Nose			
Hospitalizations:		Eyes			
		Palate			
Worse after:		Tearing			
Exercise		Morning sore throats			
Infections		Acid Reflux		**Hives, Swelling**	
Outdoors		Sinus headaches		Duration (years):	
Nighttime		Sinus infections		How often?	
Odors		Sinus x-rays		Location:	
Temp. change		CT Scan (year):			
Stress		*Worse after:* Animals			
Animals		Dust		Triggers:	
Dust		Pollen			
Seasonal		Seasonal			
Worst months:		Worst months:			

Please list all medications for your allergy conditions:	
Current Medications:	
Prior Medications:	

PLEASE COMPLETE OTHER SIDE

PT. LABEL (REQUIRED ON PAGE 1 ONLY)

REV [08/2008]
Form O9

Please list : Drug allergies _____

Food allergies _____

Stinging insect reactions _____

Prior allergy testing: Year(s) tested _____

Physician _____ City _____

Prior allergy injections: Years received _____

Response _____

Medical History

Please list all other significant medical problems and current medications you are on:

_____

_____

Prior surgery: _____

Do you have heartburn? ☐ Yes ☐ No

Smoking history: ☐ Yes ☐ No

If yes, year started _____ Year stopped _____ Average packs/day _____

Emotional factors that you feel might be important: _____

_____

Family History

	age/#	Nasal Allergy	Asthma	Skin Allergy	Drug Allergy	Other
Father (age):						
Mother (age):						
Brother (#):						
Sisters (#):						
Children (#):						
Other relatives with allergies:						

Home Environment

How many years have you lived in Southern California? _____

Type of residence: ☐ Home ☐ Apartment Year built (approx.) _____ Years lived there _____

Bedroom contents: Pillow: ☐ feather ☐ synthetic

Blanket: ☐ feather ☐ synthetic

Carpet: ☐ wool ☐ synthetic

Heating/Cooling: ☐ forced air ☐ wall furnace ☐ air conditioning

Pets: ☐ dogs Number inside _____ Number outside only _____

☐ cats Number inside _____ Number outside only _____

☐ other _____

Indoor smokers: ☐ Yes ☐ No

Water damage, indoor mold or mildew? ☐ Yes ☐ No

PT. LABEL (REQUIRED ON PAGE 1 ONLY)