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ALLERGY QUESTIONNAIRE

NAME_____ **APPT. DATE** _____ **DOB**_____

WELCOME TO OUR PRACTICE. We are looking forward to your visit. 45 minutes to 1 hour have been reserved for your initial evaluation. We need this much time at your first visit to fully review your history and to complete any necessary testing.

WE WOULD APPRECIATE YOUR FILLING OUT THIS QUESTIONNAIRE BEFORE YOUR VISIT.
By having the form completed before your visit, we'll be able to focus on your problem and your medical background. Then we'll be able to get to the most important part - YOUR TREATMENT**.**

INSTRUCTIONS: This form is designed to be as easy as possible for you, while at the same time providing all necessary information. The questionnaire covers both children and adults. Please skip over the sections that do not apply to you.

1. Most questions are designed for you to check off a statement which expresses your response. Several sections ask for a graded response from 1 to 4, describing the severity of your problem. Please leave blank if that answer is negative or does not apply.

2. For other questions you should write your response in the blank line.

3. Don't worry if you don't understand some of the questions. Just mark that area in the margin and we'll go over that part when you come in.

We look forward to meeting you!

Dr. Bruce L. Pfuetze

ALLERGY QUESTIONNAIRE

NAME_____ **Date of appointment**_____

How old are you?_____ Your sex _____ Parent's name (if child)_____

If female, are you pregnant at this time? _____yes _____ no

How did you hear about us?_____

Referring physician (unless self-referred) _____

Address_____ Phone_____

Primary Care Physician _____

Please briefly describe reason for seeking this allergy evaluation: _____

_____

_____

SMOKING HISTORY

_____ I have never smoked. _____My parent(s) smoked during my childhood.
_____ I used to smoke about ____ packs per day from 19_____ to _____.
(year) (year)
_____ I do not smoke myself, but am exposed to tobacco smoke:
_____ frequently _____occasionally _____infrequently.
_____ I am a smoker. I smoke ____ packs per day. I've smoked since _____.

SYMPTOMS

My symptoms have started recently _____ yes _____ no
My symptoms are long-standing _____ yes _____ no
If yes, how many _____ days, _____ weeks, _____ months, _____ years?
My symptoms have been getting worse over the past ____ weeks, ____ months or _____ years.

Does your asthma/allergy interfere with work ____, school ____, sports/physical activity ____, or sleep _____?

Do you have any of the following symptoms?
Please enter a number from 1 to 4 to indicate how much this bothers you:
1 = slight, 2 = moderate, 3 = severe, 4 = very severe. <u>If you do not have a symptom, leave blank.</u>

NASAL:

_____ itching, rubbing	_____ sneezing	_____ running/dripping
_____ congestion	_____ sniffing/snorting	_____ nosebleeds
_____ mouth breathing	_____ snoring	_____ sleep apnea
_____ nasal polyps	_____ hoarseness	_____ bad breath
_____ yellow or green mucus	_____ loss of smell	_____ previous nasal/facial trauma
_____ morning sore throat	_____ postnasal drainage	_____ throat clearing
_____ seasonal "hayfever" symptoms		

SYMPTOMS (continuing):

EARS:
_____ infections
_____ ringing
_____ pressure
_____ ear pain
_____ popping/cracking
_____ ear tubes
_____ itching
_____ hearing problems
_____ vertigo/dizziness

CHEST:
_____ cough
_____ shortness of breath
_____ tightness/pressure
_____ wheezing
_____ bronchitis
_____ asthma
_____ emphysema
_____ chest congestion
_____ chest pain

OTHER:
_____ lightheadedness/dizziness
_____ fatigue
_____ irritability
_____ frequent respiratory infections
_____ PMS

SINUSES:
_____ pain/headache
_____ pressure
_____ congestion
_____ sinus infections
_____ sinus surgery

EYES:
_____ itching
_____ redness
_____ tearing/watering
_____ dark, puffy circles
_____ I wear contact lenses

GASTROINTESTINAL:
_____ stomachaches
_____ gas and bloating
_____ vomiting
_____ diarrhea/loose stools
_____ irritable bowel syndrome or spastic colon
_____ ulcerative colitis/Crohn's
_____ food allergy/intolerance
_____constipation

SKIN:
_____ eczema/atopic dermatitis
_____ dry or itchy skin
_____ hives
_____ latex/rubber allergy

Of all my symptoms, I am most troubled by_____

X-RAYS

Have you had either in the past three years:
Chest x-ray ___ When? _____ Results _____
Sinus x-ray ___ When? _____ Results _____

COUGH

Is cough a problem for you? ____ yes ____ no (If no, please go on to next section.)
What do you feel is triggering your cough?
_____ I am not sure
_____ throat irritation
_____ mucus draining from my sinuses
_____ irritation in the upper chest area
_____ mucus in my chest
Have you ever been hospitalized or had to visit an emergency room because of cough or respiratory problems? ____ yes ____ no (If no, please go to next section.)
Date(s) of hospitalization(s) _____
Number of ER visits _____

HEADACHES - If headaches and other types of facial pain are not a problem for you, please go on to the next section.

Please rate how much the headaches bother you: _____
1 = slight 2 = moderate 3 = severe 4 = very severe. If none, leave blank.

How often do you get headaches?
_____ once a month or less
_____ once a week or less
_____ 2-3 days per week
_____ 4-6 days per week
_____ almost all the time

Do you have more than one type of headache? _____ yes _____ no

Where are your headaches located?
_____ cheek area below the eyes
_____ over the entire forehead
_____ low forehead area
_____ back of the head and upper neck
_____ behind the eyes
_____ temples
_____ over the bridge of the nose
_____ entire head

Does it worsen when your nasal and sinus symptoms are acting up?
_____ yes, most often my headaches worsen when nasal and sinus symptoms worsen
_____ no, there is no close relationship between my headaches and sinus symptoms

Do you have any other symptoms with your headaches?
_____ nausea
_____ vision changes
_____ one-sided (unilateral)
_____ vomiting
_____ sensitivity to light or noise

Have you pinpointed anything that can bring on your headaches or make them worse?
_____ weather changes
_____ menstrual cycle (PMS)
_____ fumes, odors, etc.
_____ female hormones (birth control pill, estrogen replacements, etc.)
_____ certain foods (please list) _____
_____ some alcoholic beverages (please list) _____
_____ other (please list) _____
_____ stress
_____ cigarette smoke

What medications have you taken for your headaches?

	Which ones help?	Which do not help?
_____ nasal and sinus medications	_____	_____
_____ over-the-counter medications	_____	_____
_____ prescription pain medication	_____	_____
_____ sometimes nothing helps. How often?	_____	

Have your headaches been evaluated by a physician in the past? _____ yes _____ no
Who performed the evaluation? _____
Did you have CT scan of the head as part of your evaluation? _____ yes _____ no
If yes, was it normal? _____ yes _____ no
Did you have CT scan of the sinuses as part of your evaluation? _____ yes _____ no
If yes, was it normal? _____ yes _____ no
Any other information about your headaches? _____

SEASONAL PATTERN - Are your symptoms worse during any season?
_____ no, my symptoms do not change with the seasons
_____ yes, my symptoms tend to get worse in:
_____ spring _____ summer
_____ fall _____ winter
_____ I have both seasonal and year-round symptoms.

PROVOKING FACTORS - What things can bring on your symptoms?
(Please enter a number (1-4) to indicate how much this bothers you:
1= slight 2 = moderate 3 = severe 4 = very severe (If none, leave blank.)

____ cat
____ dog
____ dust
____ lawn mowing
____ raking leaves
____ being outdoors
____ foods (please list) _____
_____
____ alcoholic beverages (please list)
_____

____ smells, fumes and odors
____ weather changes
____ tobacco smoke
____ exercise/physical exertion
____ stress
____ breathing cold air
____ aspirin
____ other medications (please list)
_____
_____

HOME ENVIRONMENT
Do you use either of the following in your home?
_____ a wood-burning stove _____ a kerosene stove

Do you have ____ forced hot air heating, _____ attic fan, _____ central air conditioning

Age of home? _____

Is there a pet in your home? _____ yes _____ no

	How many?	How long?
_____ dog	_____	_____
_____ cat	_____	_____
_____ bird	_____	_____
_____ other	_____	

After exposure to your pet, do you ever have symptoms? _____ no _____ yes
Describe symptoms? _____

If there is a pet in your home, does it go into your bedroom?
_____ yes, my pet can enter the bedroom
_____ and usually sleeps in the bedroom
_____ no, my pet never enters the bedroom

Were there pets in your home previously?
_____ no
_____ I don't know for sure
_____ yes ____ dog ____ cat ____ bird other _____

HOME ENVIRONMENT (continuing)

What's in your bedroom?
_____ feather pillow
_____ stuffed animals
_____ carpeting - if yes, is there a wood or tile floor underneath? _____
_____ dust control measures - if yes, please list _____
_____ central air filter
_____ water bed
_____ regular mattress
_____ down comforter

Are there smokers in your home? ____ yes, other smokers ____ no smokers at all

Is the basement ever damp, flooded or moldy? ____ yes ____ no
Is the basement finished? ____ yes ____ no
Is the basement carpeted? ____ yes ____ no

OCCUPATION_____

WORK PLACE
_____ My work environment is pretty clean
_____ The irritants in my work place include:
- _____ dust
- _____ paint fumes
- _____ chemical solvents and cleaners
- _____ cigarette smoke
- _____ other _____

These exposures in the work place are ____ mild, ____ moderate, ____ severe.

DAY CARE SETTING (for patients under 5 years of age)
Are there smokers? _____ yes _____ no
Are there pets? _____ yes _____ no
Please list other allergen/irritant exposures _____

HOBBIES
Do you frequently do any of the following?

Outdoor Hobbies:	Symptoms during or after:
_____ yard work	_____
_____ mowing	_____
_____ raking	_____
_____ farming	_____
_____ ranching	_____
_____ gardening	_____
_____ other (please list)	_____

Indoor hobbies:	Symptoms during or after:
woodwork/remodeling	_____
other (please list)	_____

MEDICATION BACKGROUND - What are your attitudes toward medication?
____ I tend not to pay much attention to the names and dosages of medications
____ I worry about reactions to medications
____ I'm usually pretty calm taking medications as long as I know why I'm taking them and what to watch for
____ I use medications, but only as a last resort
____ I often stop taking medications as soon as I feel better

ANTIBIOTICS - Have you taken antibiotics for sinus or lower respiratory problems?
____ yes ____ no If you have, please check the statements that apply to you:
____ I had good and long-lasting improvement
____ I got a little better, but not completely better
____ I got better at first, but then I got sick again soon after they were stopped
____ I did not see any significant improvement.

Which antibiotics have been helpful? _____

Which antibiotics have not been helpful?_____

MEDICATION HISTORY - Please list the medications you have taken for your condition and tell us if they were helpful or not. This should include any cortisone-type medications, i.e. prednisone, Medrol, Kenalog, Deltasone, etc.

Medication	Helpful?	Problems or Side Effects
_____	____ yes ____ no	_____
_____	____ yes ____ no	_____
_____	____ yes ____ no	_____
_____	____ yes ____ no	_____
_____	____ yes ____ no	_____
_____	____ yes ____ no	_____

Please list **all** medication you are taking now (write on back if needed): _____
_____
_____
Occasional medications (non-prescription) _____
_____
_____
Do you ever use over-the-counter decongestant nose sprays? ____ yes ____ no
If yes, which ones? _____ For how long? _____

MEDICATION SIDE EFFECTS - If you have ever experienced side effects (such as sedation, anxiety, palpitations, headaches or stomach upset) with use of allergy or asthma medications, please tell us about them. If not, please go on to the next section.

Medication	Date	Side Effects
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

ANTIBIOTIC REACTIONS - If you have ever experienced hives, rash or stomach upset with use of antibiotics, please tell us about this. If not, please go on to the next section.

Antibiotic	Date	Reaction
_____	_____	_____
_____	_____	_____
_____	_____	_____

ALLERGY SKIN-TESTING - Have you ever had allergy skin tests? _____ yes _____ no
If yes, date _____ Doctor's name _____
Do you recall the results of these tests? If so, please list any positive tests:
_____
_____
Did you ever receive allergy injections? ____ yes ____ no If yes, dates _____
Did they help? ____ yes ____ no

INSECT STINGS - If you ever had a bee sting, check the statements which best describe your reaction. If not, go on to the next section.

_____ small, painful swelling where I got stung
_____ large, painful swelling where I got stung
_____ immediate hives all over the body
_____ other _____
_____ breathing difficulties
_____ fainting
_____ treated in emergency room

SOCIAL HISTORY - Some family or social situations can affect your on-going care for chronic diseases such as asthma or allergy. Do you or your immediate family have any significant concerns or problems in the following areas:

marriage	_____ yes	_____ no
alcohol	_____ yes	_____ no
drugs	_____ yes	_____ no
financial	_____ yes	_____ no
behavioral/learning/school	_____ yes	_____ no
emotional/psychological	_____ yes	_____ no
other chronic medical problems	_____ yes	_____ no

FAMILY HISTORY - Don't worry if you can't recall exact details. Is there history of allergy in your family? (parents, grandparents, brother, sisters, children, aunts or uncles) __ yes ___ no
(If no, go to next section.)

Allergy — Relatives (please list below)

hay fever _____
sinus problems _____
eczema _____
asthma _____
food intolerance/allergy _____
hives _____
headaches _____

SURGICAL HISTORY - List the surgeries you have had in the past. If you can't remember the exact year, just estimate. If you've had no surgeries, go on to the next section.

Surgery (be sure to include all ENT procedures.) Date

_____ _____
_____ _____
_____ _____

_____ My tonsils and adenoids were taken out.
_____ My adenoids and tonsils have not been removed.
_____ My tonsils were taken out, but I am not sure about my adenoids.
_____ I have had ear tubes inserted. How many times? _____

IMMUNIZATION HISTORY

Are childhood immunizations current	____ yes ____ no
When did you have your last TB tine test?	_____ date
Result of TB tine test?	___ positive ___ negative
Date of last flu shot (influenza)?	_____ date
Date of last pneumonia (pneumococcal) vaccine?	_____ date

HIATAL HERNIA - ACID REFLUX Are you troubled by any of these symptoms?

_____ heartburn
_____ indigestion/sour stomach
_____ bitter or burning taste in your throat
_____ belching/burping
_____ pain in the upper stomach

If not, please go on to the next section.

Have you ever been diagnosed with either of the following?
_____ ulcer _____ hiatal hernia

Has your doctor ever ordered any of the following for the above problems?
_____ stomach x-rays
_____ endoscopy (looking into the stomach with a special scope)
_____ over-the-counter medications (Tums, Mylanta, Maalox, Gaviscon, etc.)
_____ prescription medications

_____ Tagamet _____ Pepcid
_____ Zantac _____ Axid
_____ Reglan _____ Prilosec
_____ Other (please list) _____

CURRENT MEDICAL CARE - Are you under a physician's care for any of the following?
_____ Eye: glaucoma or cataracts
_____ Cardiovascular: high blood pressure, coronary artery disease, congestive heart failure, ankle swelling, chest pain or mitral valve prolapse
_____ Gastrointestinal: diarrhea, constipation or abdominal pain
_____ Genitourinary: prostate problems or bladder problems
_____ Musculoskeletal: rheumatoid arthritis or arthritis
_____ Endocrine: diabetes or thyroid problems
_____ Neurologic: stroke, seizures or epilepsy
_____ Dermatologic: eczema or itching of the skin
_____ Oncologic: any type of cancer
_____ Psychiatric: depression or emotional disorders

ADDITIONAL COMMENTS (please include any conditions for which you are seeing a doctor on a regular or frequent basis): _____

_____

_____

Also include any other serious medical conditions not mentioned above: _____

_____

_____

INFANT HISTORY

If you are an adult, please fill out this section for **yourself when you were an infant**. If possible, have your mother help with these questions, if you are unsure.

Full term newborn	____ yes	____ no
Healthy newborn	____ yes	____ no
Breast fed	____ yes	____ no
Bottle fed	____ yes	____ no
Formula changes	____ yes	____ no

(Please enter a number (1-4) to indicate how much this bothered you **as an infant**:
1 = slight, 2 = moderate, 3 = severe, 4 = very severe. If none, leave blank.)

_____ milk allergy
_____ colic
_____ always hungry
_____ frequent loose stools
_____ frequent ear infections
_____ food allergy
_____ crying
_____ spitting or vomiting
_____ fussy-difficult baby
_____ eczema
_____ frequent respiratory problems/infections
_____ other serious illness_____

CHILDHOOD HISTORY

(Score as above.)

_____ milk allergy
_____ stomachaches
_____ frequent loose stools
_____ frequent ear infections
_____ fatigue
_____ school problems
_____ recurrent bronchitis or chest colds
_____ nasal polyps
_____ bed wetting (over 5 y/o)
_____ frequent lightheadedness
_____ hearing or speech problems
_____ food allergy
_____ leg aches
_____ eczema
_____ frequent respiratory problems/infections
_____ irritability
_____ hyperactive
_____ frequent headaches
_____ pneumonia
_____ recurrent croup
_____ frequent coughs
_____ other serious illnesses _____
_____

THANK YOU!

FOR PHYSICIAN USE (please leave blank)

PHYSICAL EXAMINATION: HT _____ WT _____ BP _____ P _____ RR _____ T _____ O_2 Sat _____
EARS - Nl - _____
NOSE - Nl- _____
EYES - Nl- _____
MOUTH - Nl- _____ **PHARYNX** - Nl-_____
TONSILS Nl- _____ **SKIN** - Nl_____
NECK - Nl- _____ **ABDOMEN** - Nl_____
LUNGS - Nl- _____
HEART - Nl- _____

IMPRESSION_____

RECOMMENDATIONS:
___ Sinus x-ray (Water's view)
___ Chest x-ray, PA & Lat
___ All skin test
___ Limited ST
___ PF #1 (baseline PFT)
___ PF#2 (pre-/post-BD study)
___ Tympanogram
___ Lateral neck x-ray

PATIENT INFORMATION MATERIAL:
___ Nasal allergy
___ Sinus disease
___ Preventing infection
___ Asthma booklet
___ House dust mite control
___ Central air filter
___ Molds and fungi
___ Allergic tension fatigue
___ Milk & chocolate elimination diet
___ Allergy #1 elimination diet
___ Comments on food allergy
___ Discussion of hyposensitization
___ Peak flow record
___ Respiratory record
___ Eczema
___ Cortisone - topical/systemic
___ Prednisone information

LABORATORY STUDIES:
___ CBC with Diff
___ Total eos
___ IgE
___ Ig's (GAME)
___ Pneumococcal titers
___ IgG subclasses (1-4)
___ RAST (see order sheet)
___ Throat culture
___ Sputum C & S
___ Sed rate
___ ANA
___ Alpha 1 antitryp; total
___ Alpha 1 antitryp; phenol
___ Sweat chloride
___ CT of sinuses
___ Tetanus antibody titers
___ Vitamin D level
___ Celiac screen

TREATMENT PROGRAM
1. AVOIDANCE:

2. TREATMENT:

3. IMMUNOTHERAPY:
4. RETURN: