

Do Not Take Any Antihistamines 5 Days Prior to Your Appointment

Approximate Length of Appointment: 1-3 hrs.

William S. Silvers, M.D., P.C. & Associates

ALLERGY QUESTIONNAIRE

Patient's Name:	Date of Birth:
Address:	Telephone Home: Work:
Referring Physician:	Date of Appointment:

1. INSTRUCTIONS: Please answer the questions as they relate to the person being evaluated. A complete, accurate record is important in learning about your allergy problems. **Bring this completed form with you to your first appointment.**

Briefly describe the reason for your allergy visit and what you hope to accomplish: _____

2. PROBLEMS: Have you ever had the following conditions?

Yes	No	Check all items	Age at Onset	Severity			Comments
				Mild	Mod	Sev	
		Asthma (Wheezing)					
		Breathing Problems-Shortness of breath, cough					
		Sinus Trouble					
		Hay Fever (runny/stuffy/itchy nose; sneezing)					
		Hives or Swelling					
		Eczema or Other Rashes					
		Recurrent/Frequent Infections (sinus, ear)					
		Reactions to Foods					
		Reactions to Drugs					
		Reactions to Insect Stings					

3. SYMPTOMS: Have you ever had any of the following? If not, leave blank.

	How many days last month?	Severity			Circle the Most Severe Months
		Mild	Mod	Severe	
Runny or Stuffy Nose					J F M A M J J A S O N D
Itchy Nose					J F M A M J J A S O N D
Sneezing					J F M A M J J A S O N D
Sinus Pressure Headaches					J F M A M J J A S O N D
Eyes: Red Watery Itchy					J F M A M J J A S O N D
Wheezing					J F M A M J J A S O N D
Coughing					J F M A M J J A S O N D
Wheezing or coughing with exercise					J F M A M J J A S O N D
Skin Problems					J F M A M J J A S O N D

4. MEDICATIONS: List all medications you are taking now by Name, Dosage, Times per day

	Name of Medication	Dosage	Times per Day
Present medication for allergies:			
Medication taken in the PAST for allergies:			
Present medications for other reasons:			

5. PREVIOUS ALLERGY EVALUATION AND THERAPY

Have you ever had Allergy Skin Tests? YES NO If YES - When?: RAST testing? YES NO If YES - When?:

Physician: Please list the results of testing: (If possible, please provide copies):

Have you ever received ALLERGY INJECTIONS? YES NO If YES: Please give dates: from to

6. PRECIPITATING FACTORS (TRIGGERS)

Check each Symptom Box which applies when you are exposed to:	Asthma	Nose - Ears Eyes - Throat	Headache	Eczema	Hives	Other
A. ENVIRONMENTALS						
1. Dust exposure: sweeping, vacuuming, making the bed.						
2. Molds: mildewed areas, raking leaves						
3. Animal Dander						
4. Outdoor exposure: pollens: grass, trees, weeds						
B. WEATHER/ENVIRONMENTAL CHANGES						
1. High winds						
2. Humidity						
3. Cold dry air						
4. Air conditioning/heating						
C. RESPIRATORY INFECTIONS/COLDS						
D. PHYSICAL EXERTION						
E. IRRITANTS: Tobacco smoke/strong odors/cleaning agents/aerosols/chemicals/pain						
F. POLLUTANTS: Smog/motor fumes/ozone/sulfur dioxide/nitrous oxide						
G. FOODS: Food additives, colorings, preservatives						
H. EMOTIONAL EXPRESSIONS (Laughter, crying)						
I. STRESS						
J. HORMONAL FACTORS: 1. Menses 2. Other:						
K. MEDICATIONS:						
1. Aspirin or NSAIDs						
2. OTHER:						
K. OTHER TRIGGERING FACTORS NOT LISTED:						

9. PAST MEDICAL HISTORY

A. Please list other Illnesses or Chronic Medical Conditions you have had:

B. List all hospitalizations/surgeries: Please list most recent first with reason and date.

1. _____

2. _____

3. _____

4. _____

C. Immunizations: Did you experience any significant Allergic Reaction to any administered vaccine? If YES, please note what type of reaction to which vaccine.

1. Are your immunizations up to date? YES NO
2. Date of last TETANUS: _____
3. Date of last TB TINE: _____

Indicate here any reactions to vaccines you have experienced: _____

10. FAMILY HISTORY

DO ANY MEMBERS OF YOUR FAMILY HAVE A HISTORY OF ALLERGY?

	YES	NO	If YES, list all relatives (parent, grandparent, brother, sister, children, aunt, uncle)
Asthma			
Hay Fever			
Eczema			
Hives			
Frequent pneumonia, Sinus/ear infections			
Headaches			
Other Allergies:			

IS THERE A FAMILY HISTORY OF ANY OTHER ILLNESSES?

	YES	NO	If YES, list all relatives as described above.
Emphysema/Other Lung Diseases/Tuberculosis			
Cystic Fibrosis			
Cardio-vascular Disease			
Thyroid Disease			
Glaucoma			
Diabetes			
Other:			

12. SOCIAL/OCCUPATIONAL/EDUCATIONAL HISTORY CONTINUED

12 C. EDUCATION: Please indicate highest grade completed.
 Grade School: _____ High School: _____ College: _____ Other: _____

12 D. MARITAL STATUS: Single Married Separated Widowed Number of children: _____

12 E. SEXUAL BEHAVIOR: Heterosexual Bisexual Homosexual NONE

12 F. TOBACCO SMOKING HISTORY:
 Do you presently smoke? YES NO If YES, how many years have you been smoking? _____ years
 Have you ever smoked? YES NO If YES, when did you stop? _____
 Average cigarettes per day at highest point: _____
 If you still smoke, do you think you could stop? YES NO
 Do any family members living with you now smoke? YES NO If yes, which ones? _____

12 G. DO YOU NOW OR HAVE YOU EVER USED RECREATIONAL DRUGS? YES NO If YES, were they: Oral Nasal IV

13. PSYCHOLOGICAL PROFILE

Please circle all words you would use to describe yourself (or your child if he/she is being evaluated).

Timid	Well adjusted	Anxious
Quiet	Few friends	Many friends
Aggressive	Spoiled	Shy
Forward	Dependent	Relaxed
Unfriendly	Concerned	Independent
Introvert	Depressed	Manipulative
Tense	Bustling	Extrovert
Calm	Happy	Usually ill

Do you feel that psychological issues may play a role in your (or your child's) allergy problem? YES NO
If so, how?

Please use this space to provide any additional information regarding yourself (or your child) which you feel might help us in evaluating the current condition/problem:
