

ALLERGY QUESTIONNAIRE
Allergy Group NJ

*All questions contained in this questionnaire are strictly confidential
and will become part of your medical record.*

Name (Last, First, M.I.):	<input type="checkbox"/> M	<input type="checkbox"/> F	DOB:
---------------------------	----------------------------	----------------------------	------

Primary physician's name	If patient is a child, this form is being completed by <input type="checkbox"/> mother <input type="checkbox"/> father
--------------------------	---

Who referred you to this practice? <input type="checkbox"/> primary doctor <input type="checkbox"/> friend/family <input type="checkbox"/> ins co <input type="checkbox"/> web	Your occupation:
--	------------------

What is the main reason for today's visit? (provide details)

Upper Respiratory Problems (Nose, sinus, ears, eyes)

Check box if not applicable

<input type="checkbox"/> nasal congestion <input type="checkbox"/> runny nose <input type="checkbox"/> post nasal drip <input type="checkbox"/> itchy nose <input type="checkbox"/> red or itchy eyes	<input type="checkbox"/> sinus pressure or pain <input type="checkbox"/> poor sense of smell <input type="checkbox"/> frequent ear infections <input type="checkbox"/> frequent sinus infections <input type="checkbox"/> frequent colds	<input type="checkbox"/> hoarse voice <input type="checkbox"/> other
---	--	---

Lower Respiratory Tract Problems (Chest, lungs)

Check box if not applicable

<input type="checkbox"/> frequent or constant cough <input type="checkbox"/> wheezing <input type="checkbox"/> chest tightness <input type="checkbox"/> shortness of breath	<input type="checkbox"/> asthma <input type="checkbox"/> frequent croup <input type="checkbox"/> pneumonias <input type="checkbox"/> frequent bronchitis	<input type="checkbox"/> other:
--	---	---------------------------------

Are the above symptoms seasonal? Jan Feb Mar April May June July Aug Sept Oct Nov Dec All Year No Pattern

Are the symptoms triggered by any of these?

pollen animals dust mold smoke or scents weather changes foods

Skin Problems

Check box if not applicable

<input type="checkbox"/> eczema <input type="checkbox"/> itching skin rash <input type="checkbox"/> dry skin <input type="checkbox"/> itchiness in general	<input type="checkbox"/> hives, welts <input type="checkbox"/> swelling of parts of the body <input type="checkbox"/> blistery rashes <input type="checkbox"/> pimply rashes	<input type="checkbox"/> acne <input type="checkbox"/> frequent boils <input type="checkbox"/> other:
---	---	---

Food Allergies

Check box if not applicable

Food	Reaction noted	When did the reaction occur? (age or date)	Is the food <u>completely</u> avoided?
			<input type="checkbox"/> yes <input type="checkbox"/> no
			<input type="checkbox"/> yes <input type="checkbox"/> no
			<input type="checkbox"/> yes <input type="checkbox"/> no
			<input type="checkbox"/> yes <input type="checkbox"/> no

What medications are you taking? (list both prescription and non-prescription)

Name of Drug	Which strength?	Frequency

Your Medical History:

<input type="checkbox"/> asthma <input type="checkbox"/> hay fever <input type="checkbox"/> eczema <input type="checkbox"/> hives <input type="checkbox"/> food allergies <input type="checkbox"/> high blood pressure <input type="checkbox"/> atrial fibrillation <input type="checkbox"/> MI/cardiac stent	<input type="checkbox"/> pacemaker <input type="checkbox"/> arthritis <input type="checkbox"/> cholesterol high <input type="checkbox"/> diabetes <input type="checkbox"/> thyroid low <input type="checkbox"/> emphysema/COPD <input type="checkbox"/> GERD/reflux <input type="checkbox"/> Crohn's/ulcerative colitis	<input type="checkbox"/> celiac disease <input type="checkbox"/> cancer (type): <input type="checkbox"/> chemotherapy <input type="checkbox"/> attention deficit <input type="checkbox"/> depressive disorder <input type="checkbox"/> anxiety disorder <input type="checkbox"/> other not listed (inc surgeries):
--	--	--

Smoking History I currently smoke I never smoked (skip other questions) N/A because patient is child

Have you smoked at least 100 cigarettes in your entire life? yes no
 If currently smoking, are you a everyday smoker smoke some days only former smoker, year quit _____
 cigarettes #pks./day _____ pipe - #/day _____ cigars - #/day _____ smokeless tobacco - #/day _____
 # of years total _____

Family history of allergies? (hay fever, asthma, eczema, food allergies, drugs)

father mother brothers or sisters aunts or uncles grandparents

Review of Systems**Circle any symptoms that apply to you:** Not applicable

<i>General:</i> insomnia, tiredness	<i>Throat:</i> sore throat, hoarseness, postnasal drip	<i>Neuro:</i> anxiety disorder, panic attacks, depression
<i>Eyes:</i> itchy eyes, watery eyes, swollen eyes	<i>Lungs:</i> cough, chest tightness, wheezing, shortness of breath	<i>Joints:</i> swollen joints
<i>Head:</i> severe or frequent headaches, dizziness	<i>Chest/heart:</i> chest pain, palpitations	<i>Skin:</i> hives, easy bruising
<i>Ears:</i> ear congestion, decreased hearing, frequent ear infections	<i>GI:</i> difficulty swallowing, acid reflux, stomach pain, diarrhea, nausea, vomiting	Other not listed:
<i>Nose:</i> itchy nose, stuffiness, sinus pressure		

Allergies to Medications

Name of drug ...	Reaction you had

Environmental Survey

What kind of trees are on your property, if known?

Heating system: forced air other

Mold problems? yes no

Allergy encasing on mattress? yes no

Feather pillow or down comforter? yes no

Pets: no yes (*how many?*) dogs _____ cats _____ other _____

Cigarette smokers inside the house? yes no

Any school or workplace exposures you are concerned about?

For office use: