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ALLERGY SURVEY SHEET

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 ❑ Male ❑ Female

Address ____

Home phone ___________________________________ Work phone _______________________________

Marital Status ❑ Single ❑ Married ❑ Widowed ❑ Divorced ❑ Separated

Health insurance ________________________________ Referred by _______________________________

Family doctor ___________________________________ Other doctors consulted _____________________

Date of last physical ______________________________

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

Area	***From what date***	***To what date***

List your past occupations chronologically, giving dates:

Occupation	***From what date***	***To what date***

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Employer's name ________________________________ Type of work ________________________________

Highest level of education received _________________

Hobby (what do you do in your spare time) ____

Past hobbies ____

Hobbies of other family members living with you ____

HABITS ____

Do you smoke?

❑ Cigarettes If yes, how many a day? ____________ For how many years? ________

❑ Pipe If yes, how many a day? ____________ For how many years? ________

Did you formerly smoke? Yes ❑ No ❑ If yes, when did you quit?_______________________

ALCOHOL:

Did you drink? Yes ❑ No ❑ What do you drink? ______________________________________

If yes, how many drinks a day/week? ____________ Have you ever been treated for alcoholism? Yes ❑ No ❑

EXERCISE:

How often? ______________________ What kind? ______________________________________

SLEEP:

Do you sleep well? Yes ❑ No ❑ Hours a day: ______________________________________

DIET:

Are you on a diet? Yes ❑ No ❑ If yes, 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 tensions, if any: ____

CHIEF COMPLAINT (what led you to consult an allergist)

Problem	***Date on onset***
1. ______________________________	______________________________
2. ______________________________	______________________________
3. ______________________________	______________________________
4. ______________________________	______________________________

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REVIEW OF ALLERGY HISTORY ______________________________

I. Early Childhood *(check if applicable)*

❑ Colic in infancy ❑ Eczema in childhood ❑ Feeding problem (milk, eggs, etc)
❑ Frequent ear infections ❑ Frequent colds ❑ Bronchitis

II. Nasal symptoms

Age of onset of earliest nasal symptoms ______________

Description of symptoms

❑ Nasal blockage ❑ Nasal congestion ❑ Sneezing
❑ Sniffing ❑ Itchy nose ❑ Runny nose

Post-nasal drainage ❑ Constant ❑ Periodic ❑ Occasionally ❑ Never a problem

Clearing of throat ❑ Frequent ❑ Occasional ❑ Nasal speech ❑ Loss of taste
❑ Loss of smell ❑ Nose bleeds ❑ Sinus headaches

Have you ever been told that you had treatment for the following? ❑ Nasal polyps ❑ Deviated nasal septum
❑ Nasal/sinus surgery or washing ❑ Broken nose ❑ Sinus infections ❑ Sinus x-ray (When?) ________

Which of the following aggravates your nasal/sinus symptoms?

1. ANTIGENS

❑ Exposure to house dust: ❑ Sweeping ❑ Dusting ❑ Housecleaning ❑ Worse in the morning
❑ Worse of night ❑ Worse when the furnace is on

❑ Exposure to pollens: ❑ Lawn mowing ❑ Auto rides ❑ Golf ❑ Lying on grass
❑ Working in the garden ❑ Pulling weeds

❑ Exposure to musty moldy areas: ❑ Hay ❑ Barn ❑ Circuses ❑ Damp basements
❑ Raking leaves ❑ Eating cheese ❑ Mushrooms ❑ Beer ❑ Wine

Seasonal occurrences: ❑ All year ❑ Fall (Aug-Sep) ❑ Spring (Mar-Apr)
❑ Summer (May-Jun) ❑ Winter

Foods
(specify which foods aggravate nasal symptoms) ______________________________

Animal contact:(specify which animals) ______________________________

Vacation: Where worse: ______________________ Better: ______________________

Location: Where worse (home, work, farm, school, church, etc.) ___________ 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** ❑
6. **PREGNANCY** ❑
7. **MENSTRUATION** ❑
8. **MEDICATIONS** (which one aggravates nasal symptoms)

   ❑ Aspirin ❑ Birth control pills ❑ Hormone pills ❑ Blood pressure pills ❑ Other _____________________

III. Eye Symptoms

Age of onset of earliest eye symptoms ________

Description: ❑ 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? ____

ASSOCIATED HAY FEVER SYMPTOMS

❑ Ears itch ❑ Wear infection ❑ Hearing loss ❑ Ear drainage ❑ Itchy throat ❑ Fatigue ❑ Low "pep"

IV. Asthma

Age of onset of earliest asthma 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 spurtum per day: ❑ 1 teaspoon ❑ 1 tablespoon ❑ 1 cup ❑ More than a cup

Color of phlegm ❑ Clear ❑ Grey ❑ Yellow ❑ Green ❑ Brown ❑ Black ❑ Blood tinged

Severity of asthma Frequency of lasting symptoms ❑ Daily ❑ Weekly ❑ Monthly ❑ Periodic

How many attacks in the last one year? ____

Approximate number of school/work days missed per year due to asthma? ____________________________

Do you have trouble sleeping because of asthma? ❑ Yes ❑ No

Do you awake at night short of breath or wheezing? ❑ Yes ❑ No

If *adrenalin shots* given for asthma, list dates ____

If *cortisone pills/*shots given for asthma, list dates ______________________________________

List emergency room visits for asthma ____

List hospitalization for asthma with name of hospital and date __________________________________

In the last 5 years, asthma has been getting: ❑ Worse ❑ Better ❑ Same

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Which of the following aggravates your asthma:

1. ALLERGENS

❑ Exposure to house dust: ❑ Sweeping ❑ Dusting ❑ Housecleaning ❑ Worse in the morning
❑ Worse of night ❑ Worse when the furnace is on

❑ Exposure to pollens: ❑ Lawn mowing ❑ Auto rides ❑ Golf ❑ Lying on grass
❑ Working in the garden ❑ Pulling weeds

❑ Exposure to musty moldy areas: ❑ Hay ❑ Barn ❑ Circuses ❑ Damp basements
❑ Raking leaves ❑ Eating cheese ❑ Mushrooms ❑ Beer ❑ Wine

Seasonal occurrences: ❑ All year ❑ Fall (Aug-Sep) ❑ Spring (Mar-Apr)
❑ Summer (May-Jun) ❑ Winter

Foods
(specify which foods aggravate nasal symptoms) ____

Animal contact:(specify which animals) ____

Vacation: Where do you normally vacation?__________________ What month of the year? _____________

Where worse: ____ Better: _____________________________

Location: Where worse (home, work, farm, school, church, etc.) __________ Better: ___________________
What month of the year?__________________________

Where worse:_________ Better:___________

Location: Where worse (home, work, farm, school, church, etc.) _______________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. EXERCISE ❑ Wheezing during exercise ❑ Wheezing right after exercise
❑ Cannot exercise due to shortness of breath/wheezing

5. EMOTIONAL ❑ Asthma worse when emotionally upset ❑ Asthma makes you panicky

6. INFECTIONS Asthma starts/gets worse with the following:
❑ Sinus infections (yellow nasal drainage, sinus pain)
❑ Bronchitis (coughing yellow or green phlegm)
❑ Head colds (relapse of asthma coincides/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 asthma)

Has there been pneumonia associated with asthma? ❑ Yes ❑ No

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Has there even been fever/chills with asthma? ❑ Yes ❑ No If yes, how many times? __________________

7. ASPIRIN INTOLERANCE TYPE - ❑ Asthma worse after taking aspirin ❑ Yellow pills of any kind

8. OVER USE OF INHALERS

What inhaled medicines do you use for asthma? ____

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 ❑ Hital or esophagus hernia

Can you sleep flat on your bed? ❑ Yes ❑ No How many pillows do you use?_________________

When was your last chest x-ray? _______________ Have you had an abnormal chest x-ray? ❑ Yes ❑ No

V. Eczema

Site of onset ____ Age of onset ______________________

Areas which have been involved ____

Areas most commony involved in the 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 ❑ Periodically ❑ Constant

Location: ❑ Face ❑ Trunk ❑ Arms ❑ Legs ❑ Hands ❑ Feet ❑ Other ___________________________

Associated symptoms: ❑ Breathing trouble ❑ Choking ❑ Throat swelling ❑ Lip swelling

❑ Stomach pains ❑ Hay fever

List all known/suspected things that may cause your hives (including foods) _____________________________

____

VII. Contact Allergy

Do you have skin rashes after contact with: ❑ poison ivy ❑ poison sumac ❑ poison oak

When was last attack? ____

What treatment was given? ____

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

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

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

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VIII. Photosensitivity reactions

Did you break out after exposure to sunlight? ❑ Yes ❑ No

When was the last attack? ____

What medicines were you on at the time? ____

IX. Headaches

Age of onset _________ Type ❑ Aching ❑ Throbbing ❑ Dull pain ❑ Other ________________________

Frequency - ❑ Daily ❑ Weekly ❑ Other ____

Is headache associated with: ❑ Nausea ❑ Disturbance of vision

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? ❑ Bee ❑ Wasp ❑ Bumble bee

❑ Yellow Jacket ❑ Hornet ❑ Sweat bee ❑ Flea ❑ Other ___________________________________

Description of symptoms: ❑ Mild swelling at bite ❑ Moderate swelling at bite ❑ Severe generalized swelling
❑ Breathing trouble ❑ Hives

❑ Other ____

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

____

____

XI. Food allergy

Do any foods cause an adverse reaction? ❑ Yes ❑ No If yes, which foods? ____________________________

What reaction? ____

If any special allergy diets, please specify: ____

Type of allergy diet ____

Conclusions reached ____

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XII. Drug allergy

Penicillin: When last taken? ____ ❑ Injection ❑ Tablets

What type of adverse reaction? ____

What treatment given? ____

Aspirin: How often taken? ❑ Daily ❑ Weekly ❑ Seldom ____times a week

List any adverse reactions from aspirin ____

OTHER DRUG	LAST TAKEN	HOW MUCH LATER REACTION OCCURRED	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.)

	Medication previously used	What color?	Date and How often used	Helped (Yes or no)	Date stopped taking	Describe any ill effects/reactions
1						
2						
3						
4						
5						
6						
	Medication currently used	**What color?**	**Date and How often used**	**Helped (Yes or no)**	**Date stopped taking**	**Describe any ill effects/reactions**
1						
2						
3						
4						
5						
6						

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XIV. Immunizations

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

DPT (diphtheria, pertussis, tetanus)			
Oral polio			
Small pox			
Measles 1 – Rubeola			
Measles 2 – Rubella			
Mumps			
TB Test			
Histoplasmin			
Other			
Other			

Was TB skin test positive? ❑ Yes ❑ No Did you have adverse reaction to any immunization? ❑ Yes ❑ No

XV. Family History

Relation		**If living**		**If deceased**		**Please list any allergy symptoms, asthma, hay fever, "sinus" trouble, hives, eczema, drug allergy, other**
		Age	Health	Age at death	Cause	
Father						
Mother						
Brothers	1					
	2					
	3					
	4					
Sisters	1					
	2					
	3					
	4					
Husband/wife						
Sons	1					
	2					
	3					
	4					
Daughters	1					
	2					
	3					
	4					

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

____

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XVI. Environmental History

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

Time lived at present home? __________________________ How old is dwelling? _____________________

Check if animals in your home:

ANIMAL	INSIDE	OUTSIDE	BOTH	NO. OF YEARS
DOG	❑	❑	❑	___________
CAT	❑	❑	❑	___________
BIRDS	❑	❑	❑	___________
OTHER_______________________	❑	❑	❑	___________

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 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

If yes, when? _______________________________ What brand/varnish?_________________________

How many indoor plants?__________________________ In which room? ___________________________

How many bedrooms? ____________________________

Is there an aquarium in the home? ❑ Yes ❑ No In which room? ___________________________________

Are there damp, musty areas in the home? ❑ Yes ❑ No If yes, where? ______________________________

Which family members living with you smoke? ____

Types of trees in your neighborhood ____

Types of grass, flowers, shrubs in your yard ____

Bedroom

Pillows ❑ Feather/down ❑ Foam ❑ Kapok ❑ 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

Mention any unusual allergy exposure at work or home ____

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XVII. Previous Allergy Work Up

Have you had allergy tests/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 – If yes, what reaction? ____________________________

List any other problems that you think are caused by allergy, not listed above ___________________________

____

XVIII. Which of the following are present in your home? Check in the appropriate box indicating whether in your bedroom or elsewhere in the house or not at all. Checks labels carefully if available and make every effort to survey and answer accurately as this information is most important in the control of your allergy. Remember the closets, basements, floor coverings, pads under carpets, etc.

Your Bed room	Elsewhere in House	None In House	Items	Where found (Please circle item)
❑	❑	❑	**Feathers**	Pillows, down cushions, couches, and other upholstered articles, live poultry, birds, sleeping bags Cat hair is sometimes used to trim toys
❑	❑	❑	**Cattle Hair**	Rugs, wall hangings, pads under carpeting, upholstery
❑	❑	❑	**Mohair, Alpaca**	Sweaters, coats, suits
❑	❑	❑	**Horse hair**	Saddles, saddle blankets, riding clothes and gear, love seats, sofas, upholstery, mattresses, antique furniture
❑	❑	❑	**Rabbit hair**	Angora sweaters, angora collars and trim, trim on stuffed toys, non-synthetic imitation furs, felt and felt hats, carpet pads
❑	❑	❑	**Camel hair**	Jackets, coats, some paint brushes
❑	❑	❑	**Sheep wool**	Blankets, clothing, comforters
❑	❑	❑	**Hemp**	Rope, pads under carpets, rope articles
❑	❑	❑	**Kapok**	Pillows, cushions, upholstery, sleeping bags, mattresses, stuffed toys
❑	❑	❑	**Jute**	Gunny sack, crocus cloth, burlap, “Polynesian” articles such as grass skirts, handbags, carpets, curtains, place mats, and occasionally in other coarse cloths and pads under carpets. Door mats, gymnasium mats, tropical fumiture, some box strings
❑	❑	❑	**Coconut fibers**	
❑	❑	❑	**Cotton, Felted cotton**	Mattresses, upholstery, comforters