Park Allergy Center

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ALLERGY/ASTHMA QUESTIONNAIRE

How did you hear about us: (circle) Physician Referral Family/Friend Website Phonebook Other_____

Name:_____ Age:_____ Appointment Date:_____

Birthdate: _____ Occupation/Place of Work:_____

Please Circle: African American Asian Caucasian Hispanic Middle Eastern Other: _____

Describe the problem(s) you have been experiencing:_____

_____

_____

Length of time you have had the problem(s):_____

If you have been away from home in the past year, were symptoms better or worse while there? (Circle) Better Worse No Difference

Which season(s) bother your symptoms the most? (Circle)
All the time Spring Summer Fall Winter Changes of seasons

Previously evaluated by an allergist? (circle) Yes No **If yes, who and when:**_____

_____

Were skin test performed? (circle) Yes No **If yes, what were the results:**_____

_____

Have you ever received allergy shots before? (circle) Yes No **If yes, when did you start and end your treatment?**_____

If yes, did you feel allergy shots were helpful? (circle) Yes No

ALLERGY HISTORY

Do you live in a (circle): House Apartment Condo Dorm Mobile Home Other_____

Age of dwelling/Year built:_____ **Length of Occupancy:**_____

Mattress (circle): Conventional Water Air Other _____**How old?** _____

Pillow (circle): Feather Foam Dacron/Polyester Other_____ **How old?**_____

PATIENT NAME:_____

Pets (circle and indicate how many): Cat_____Dog_____Other furry pets_____

Ever been stung by a bee, wasp, hornet? (circle) Yes No I**f yes, describe the reaction** _____

Ever had poison ivy/oak/sumac? (circle) Yes No **Stuffy nose that worsens at night (circle)?** Yes No

Adverse reaction to medications (specify name/reaction):_____

Adverse reaction to foods (specify food/reaction):_____

Adverse reaction to latex or rubber:_____

Adverse reaction to previous immunizations:_____

Current medications:_____

_____

Past and current medical problems:_____

_____

Past surgeries:_____

SOCIAL HISTORY

Who lives with you in your home (circle): Live alone Roommate Significant other Spouse Siblings Parents

Does anyone in your home smoke: Yes No

Patient's smoking status (circle): Current Former Never

Alcohol use (circle): Daily Weekly Monthly Yearly Never

Children (circle): Yes No **If yes, how many boys?** _____ **girls?**_____

FAMILY HISTORY

Parents (circle): Seasonal/Animal Food allergies Asthma Eczema Other_____

Siblings (circle): Seasonal/Animal Food allergies Asthma Eczema Other_____

Children (circle): Seasonal/Animal Food allergies Asthma Eczema Other_____

REVIEW OF SYSTEMS Circle and describe any other problems not mentioned above

Eyes	Muscles/bones/joints	
Ear/Nose/Throat	Skin	_____
Heart	Neurological	
Lungs	Psychiatric	_____
Gastrointestinal	Hormonal	
Genital/bladder/kidney	Blood/lymphatic	_____