PACIFIC ENT MEDICAL GROUP, INC.
ALLERGY QUESTIONNAIRE

I. MAIN REASON FOR TODAY’S VISIT
What is the main reason for today’s visit?
☐ Hayfever or “sinus” ☐ Eye problems ☐ Asthma/chronic cough ☐ Headaches
☐ Eczema or rash ☐ Hives ☐ Food allergy ☐ Frequent infections
☐ Other __________________________

When was the first time you had this problem? _____________________________________

What time of day are symptoms worse? ☐ Morning ☐ Afternoon ☐ Night ☐ All the time

During which months is it most severe? (circle)
Jan/Feb/Mar/Apr/May/Jun/Jul/Aug/Sept/Oct/Nov/Dec ☐ All year

Are symptoms worse in certain locations? ☐ Home ☐ Work ☐ Outdoors ☐ Indoors
☐ Other __________________________

Suspected causes: ☐ Trees ☐ Weeds ☐ Grass ☐ Mold ☐ Dust ☐ Perfumes ☐ Scents ☐ Heat
☐ Cold ☐ Weather changes ☐ Smoke ☐ Stress ☐ Cats ☐ Dogs ☐ Other animals ________
☐ Foods ________________ ☐ Other __________________________

How long have you lived in this area? ______________ Moved from where? ______________

Where did you grow up? ______________________

II. MEDICATION HISTORY
What medications have been HELPFUL now or in the past? __________________________

________________________________________________________________________

What medications have been UNHELPFUL? __________________________

________________________________________________________________________

Have you ever been prescribed an EpiPen (adrenalin/epinephrine)? Y/N for __________________

III. ALLERGY HISTORY
Allergy Testing: Date of last skin testing _______ What were you allergic to? __________

Allergy Shots: ☐ Never ☐ Yes When? _________ Where? __________ Doctor? _________

How long did you take shots? __________ Did they help? Y/N

Any problems with skin testing or shots in the past? ☐ No ☐ Yes, describe ______________
IV. ENVIRONMENTAL HISTORY

Occupation/grade in school ________________________________

Vaccinations current? ☐ Yes ☐ No

Pets (type/number) ____________________________ How long? ______________

☐ Inside ☐ Outside ☐ Both ☐ In bedroom

Do you have increased allergy symptoms around animals? ☐ No ☐ Yes ______________

Home Age of building ____________ ☐ Water damage/leaks ☐ Visible mold/musty odor

Flooring ☐ Carpet ☐ Tile ☐ Hardwood ☐ Throw ☐ Rugs

Carpet in bedroom? Y/N Window coverings? ☐ Cloth ☐ Shutters ☐ Blinds

Fans ☐ No, not used ☐ Yes, in rooms

Workplace/School ☐ Mold ☐ Animals ☐ Chemical Exposure ☐ Paint fumes ☐ Smoke ☐ Other

V. FAMILY HISTORY

List family members affected.

Allergies ____________________________ Hives/Angioedema ____________________________

Sinus Problems ________________________ Emphysema ____________________________

Asthma ______________________________ Eczema ____________________________

Other diseases that run in family ______________________________