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 _____