Initial Allergy Questionnaire and His-

No Antihistamines for 72 hours prior to Testing appointments

Your Appointment is on:

DATE: _____

TIME: _____

WITH: ☐ **Jean Carney, MD**

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1. **Please prepare 3 days before your visit!**

2. Complete this form before your visit and bring it with you.

3. Skin testing is an important part of most Allergy evaluations. For this to be done, **antihistamines will need to be stopped for 3 days before the visit.** Please call us for advice if you think stopping them would be difficult.

   Common **antihistamines** include:

MEDICATION	MEDICATION FOUND IN
cetirizine	Zyrtec
chlorphenramine	Chlortrimeton, others
clemastine	Tavist
cyproheptadine	Periactin
diphenydramine	Benadryl, sleep aids
fexofenadine	Allegra
hydrozyzine	Atarax, Vistaril
loratadine	Claritin, Alavert
azelastine	Astelin nasal spray
azelastine	Optivar ophthalmic
olopatadine	Patanol ophthalmic
epinastine	Elastat ophthalmic

4. Asthma and other medication **should not** be stopped.

5. Over-the-counter cold or decongestant medications that are labeled as “nondrowsy” need not be stopped.

   Prescription nasal spray may be continued, with the exception of Astelin.

6. Amitriptyline, nortriptyline, imipramine, trimipramine, and doxepin are medications that can interfere with skin testing, but we do not suggest stopping them since it’s not always safe to do so.

7. Plan on 2 hours for your visit.

8. Short sleeves make testing easier.

Initial Allergy Questionnaire and History

Name: _____
Date: _____
Birth date: _____, Age: _____
gender: _____

(For use by physician)

Chart # _____
Date: _____
Referred by, or regular MD:
_____

Main reason(s) for the visit:

(Please check all that apply)

Hay fever	☐	Asthma	☐
Nasal trouble	☐	Hives or swelling episodes	☐
Sinus trouble	☐	Eczema	☐
Shortness of breath	☐	Food reactions	☐
Chronic cough	☐	Bee sting reaction	☐
Latex/rubber reaction	☐	Medication reaction	☐

Others: _____

These symptoms started _____ years ago (or _____ months ago), at the age of _____

Recurring or current symptoms:

	None	Mild	Severe		None	Mild	Severe
Plugged nose	☐	☐	☐	Swollen eyes	☐	☐	☐
Mouth-breathing	☐	☐	☐	Sinus pressure/headache	☐	☐	☐
Runny nose	☐	☐	☐	Loss of sense of smell	☐	☐	☐
Post-nasal drainage	☐	☐	☐	Ear plugging	☐	☐	☐
Sneezing	☐	☐	☐	Coughing	☐	☐	☐
Nasal itching	☐	☐	☐	Wheezing	☐	☐	☐
Eye itching	☐	☐	☐	Shortness of breath	☐	☐	☐
Red eyes	☐	☐	☐	Skin itching or eczema	☐	☐	☐
Watery eyes	☐	☐	☐	Hives or swelling episodes	☐	☐	☐

Others: _____

What is the color of the nasal secretion, post-nasal drainage, or sputum?

☐ clear ☐ White ☐ yellow ☐ green ☐ bloody ☐ others: _____

(continued next page)

Previous allergy tests? ☐ Yes ☐ No

When? _____ By whom? _____

What allergies were suggested by the tests? _____

_____

Previous allergy shots? ☐ Yes ☐ No From when to when? _____

Previous chest x-ray? ☐ Yes ☐ No When was the last one _____

Previous breathing tests? ☐ Yes ☐ No When was the last one? _____

Number of emergency roonm visits for this problem in the past one year: _____

Has this condition required a stay in the hospital overnight? ☐ Yes ☐ No When last? _____

Number of work/school days missed due to this problem in the past one year: _____

Does this problem limit activities? ☐ Yes ☐ No

Does this condition interfere with sleep? ☐ Yes ☐ No

Check the months during which you have symptoms:

	None	Mild	Severe		None	Mild	Severe
January	☐	☐	☐	July	☐	☐	☐
February	☐	☐	☐	August	☐	☐	☐
March	☐	☐	☐	September	☐	☐	☐
April	☐	☐	☐	October	☐	☐	☐
May	☐	☐	☐	November	☐	☐	☐
June	☐	☐	☐	December	☐	☐	☐

Symptoms are improved by travel:

☐ To a dryer climate

☐ To the mountains

☐ To the beach

☐ Out of state _____, Where? _____

(for use by physician)

(continued next page)

Things you notice make the symptoms worse:
(Check all that apply)

- ☐ House cleaning
- ☐ Making the bed
- ☐ Lawn mowing
- ☐ Raking leaves
- ☐ Moldy or damp areas
- ☐ Clear weather
- ☐ Rainy weather
- ☐ Being outdoor
- ☐ Being indoor
- ☐ Cool air
- ☐ Warm air
- ☐ Cat dander
- ☐ Dog dander
- ☐ Other animals _____
- ☐ Smoke
- ☐ Perfumes
- ☐ Hair sprays
- ☐ Soap powders
- ☐ Laughing or crying
- ☐ Exercise
- ☐ Lying down
- ☐ Getting up in the morning
- ☐ Colds or flu
- ☐ Aspirin, ibuprofen, Aleve
- ☐ Food **Type of reactions**
  1. _____ _____
  2. _____ _____
  3. _____ _____
  4. _____ _____

Tobacco exposure:

Do you now smoke or use tobacco? ☐ Yes ☐ No

If no, did you smoke in the past? ☐ Yes ☐ No

If yes, how much?

_____ pack(s) per day, for

_____ years, until _____ years ago.

Does any other person who lives with you smoke?

Who?_____

Does anyone smoke in the home? ☐ Yes ☐ No

(continued next page)

(for use by physician)

Environment:

Number of years living in this area: _____

In current home: _____

Please list other areas lived in from birth to present:

_____

_____

_____

Home settings:

☐ Urban	☐ Apartment
☐ Rural	☐ Mobile home
☐ Older house	☐ Farm
☐ Newer house	☐ Wooded
☐ Manufactured home	☐ Wetland

Cats: _____ come in the house and

_____stay outside

Dogs: _____ come in the house and

_____ stay outside

Birds: What type? _____

Other pets: _____

Other outside animals: _____

What pets are allowed in the bedroom? _____

What pets had previously lived in your current home or may have left dander in your furntures?: _____

_____

_____

Is a feather pillow or comforter used regularly?

☐ Yes ☐ No

Heat:

Gas	Forced air
Electric	Zonal
Oil	Wood stove
	Other _____

Watery damage or musty odor at home? ☐ Yes ☐ No

Are there any basement living areas? ☐ Yes ☐ No

More than 5 house plants? ☐ Yes ☐ No

Any plants in the bedroom? ☐ Yes ☐ No

(for use by physician)

(continued next page)

Work/School/Hobby exposures:

Are there more symptoms at work or school?

☐ Yes ☐ No

Occupation: _____

Known exposure at work:_____

_____

Do others at work have similar symptoms?

☐ Yes ☐ No

Prior work exposure? _____

_____

Exposures related to other activities/hobbies: _____

_____

General medical review of systems:

- ☐ Unexplained weight gain or loss
- ☐ Frequent headaches
- ☐ Eye disease or recent vision changes
- ☐ Frequent sore throat
- ☐ Recurrent pneumonia
- ☐ Spitting up blood
- ☐ Lung diseases other than asthma
- ☐ Heart disease
- ☐ High blood pressure
- ☐ Foot/ankle swelling
- ☐ Need for more than one pillow to sleep
- ☐ Frequent heartburn or stomach indigestion
- ☐ Other current stomach or intestinal problems
- ☐ Liver disease
- ☐ Arthritis
- ☐ Seizure
- ☐ Skin disease or rashes
- ☐ Diabetes
- ☐ Tuberculosis
- ☐ Infection starting outside of U.S.A.
- ☐ Sinus or nasal surgery
- ☐ Tonsillectomy or adenoidectomy
- ☐ Indications of current pregnancy
- ☐ HIV infection

Other condition which might influence this evaluation:

_____

_____

(continued next page)

(for use by physician)

Family (genetic) history:

If you know of allergies in any of your BLOOD RELATIVES, show which relatives were affected:

	Sisters	Brothers	Mother	Father	Children	Aunts	Uncles	Grandparents
Hayfever, nasal allergies								
Asthma								
Eczema								
Hives								
Adverse reaction to food								

(for use by physician)

Medications:

Please list any medications (prescription, herbal, or over-the-counter) you have tried for the condition(s) which prompted this visit.

Medication	Current use	Effectiveness	Side effects

Other comments or information you would like to bring to our attention: