



# Initial Allergy Questionnaire and History

No Antihistamines for  
72 hours prior to  
Testing appointments

## Your Appointment is on:

DATE: \_\_\_\_\_

TIME: \_\_\_\_\_

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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
<i>cetirizine</i>	Zyrtec, Aller-Tec
<i>chlorpheniramine</i>	Chlortrimeton, others
<i>clemastine</i>	Tavist
<i>cyproheptadine</i>	Periactin
<i>diphenhydramine</i>	Benadryl, sleep aids
<i>fexofenadine</i>	Allegra, Aller-fex
<i>hydroxyzine</i>	Atarax, Vistaril
<i>loratadine</i>	Claritin, Alavert
<i>azelastine</i>	Astelin, Astepro
<i>azelastine</i>	Optivar ophthalmic
<i>olopatadine</i>	Patanol, Pataday
<i>bepotastine</i>	Bepreve ophthalmic

4. Asthma and other medication **should not** be stopped.
5. Over-the-counter cold or decongestant medications that are labeled as “non-drowsy” need not be stopped.

Prescription nasal spray may be continued, with the exception of Astelin, Astepro and Patanase

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



(For use by physician)

Name: \_\_\_\_\_  
 Date: \_\_\_\_\_  
 Birth date: \_\_\_\_\_, Age: \_\_\_\_\_  
 gender: \_\_\_\_\_

Chart # \_\_\_\_\_  
 Date: \_\_\_\_\_  
 Referred by, or regular MD: \_\_\_\_\_

## Main reasons for the visit:

(Please check all that apply)

- |                       |                          |                            |                          |
|-----------------------|--------------------------|----------------------------|--------------------------|
| Hay fever             | <input type="checkbox"/> | Asthma                     | <input type="checkbox"/> |
| Nasal trouble         | <input type="checkbox"/> | Hives or swelling episodes | <input type="checkbox"/> |
| Sinus trouble         | <input type="checkbox"/> | Eczema                     | <input type="checkbox"/> |
| Shortness of breath   | <input type="checkbox"/> | Food reactions             | <input type="checkbox"/> |
| Chronic cough         | <input type="checkbox"/> | Bee sting reaction         | <input type="checkbox"/> |
| Latex/rubber reaction | <input type="checkbox"/> | Medication reaction        | <input type="checkbox"/> |

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        | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Swollen eyes               | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Mouth-breathing     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Sinus pressure/headache    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Runny nose          | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Loss of sense of smell     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Post-nasal drainage | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Ear plugging               | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Sneezing            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Coughing                   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Nasal itching       | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Wheezing                   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Eye itching         | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Shortness of breath        | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Red eyes            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Skin itching or eczema     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Watery eyes         | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Hives or swelling episodes | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

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 room 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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	July	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
February	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	August	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
March	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	September	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
April	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	October	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
May	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	November	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
June	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	December	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Symptoms are improved by travel:**

- To a dryer climate
- To the mountains
- To the beach
- Out of state \_\_\_\_\_, Where? \_\_\_\_\_

**(for use by physician)**

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**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
- |          | <b>Type of reactions</b> |
|----------|--------------------------|
| 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?

\_\_\_\_\_ packs 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

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(for use by physician)



**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:

**(for use by physician)**

Sisters  
 Brothers  
 Mother  
 Father  
 Children  
 Aunts  
 Uncles  
 Grandparents

Hay fever, nasal allergies								
Asthma								
Eczema								
Hives								
Adverse reaction to food								

**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:**

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