



Initial Allergy Questionnaire and History

No Antihistamines for 72 hours prior to Testing appointments

Your Appointment is on:

DATE: _____

TIME: _____

- WITH: Jean Carney, MD
 Kuo Casey Chang, MD
 Austin Sargent, MD, PhD
 Andrea Moore, PA-C
 Anne Dahlkemper, PA-C

Office:

- Asthma Allergy Centre-Tigard Office
Hwy 217 at Greenburg Rd.,
9735 SW Shady Lane, Suite 102
Tigard, OR 97223
(503) 620-5614
- Asthma Allergy Centre-Newberg Office
700 N. Deborah Rd., Suite 220
Newberg, OR 97132
(503) 538-7348
- Asthma Allergy Centre-Aloha Office
1960 NW 167th Place, Suite 102
Aloha, OR 97006
(503) 645-8427
- Asthma Allergy Centre-McMinnville Office
1709 NE 27th St., Suite C
McMinnville, OR 97128
(503) 434-9435

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)

(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?

_____ 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

(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
- Rural
- Older house
- Newer house
- Manufactured home
- Apartment
- Mobile home
- Farm
- Wooded
- 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 furniture? _____

Is a feather pillow or comforter used regularly?

- Yes No

Heat:

- Gas
- Electric
- Oil
- Forced air
- Zonal
- 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:

(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:
