Allergy & Rheumatology Medical Clinic, Inc.
Allergy Questionnaire

Name:_____ Date:_____

Please fill in the blanks and circle other applicable answers. Feel free to make additional comments. Base your answers on your own observations and not what you have been told by others or what you may know from previous skin test results. Though these questions are rather detailed, the information provided will be of major assistance to the doctor in helping you.

SYMPTOMS Do you have:

Rhinitis (Sneezing, runny nose)	Yes	No	Asthma (Wheezing, short of breath)	Yes	No
Hives (Welts on skin which itch)	Yes	No	Eczema	Yes	No
Eye Symptoms	Yes	No	Sinus disease	Yes	No

PLEASE CIRCLE THE TIME OF THE YEAR WHEN YOUR SYMPTOMS ARE WORSE:

Symptoms same all year round? Yes No Symptoms Worse: Winter Spring Summer Fall

HOUSE DUST

Do you get worse after exposure to house dust? Yes No

FOODS

Do any food make your worse? Yes No
Which foods?_____

Symptoms produced_____

Have any special allergy diets been tried in the past? Yes No

Type of Allergy Diet_____

Conclusions reached_____

DRUGS

Any drug allergies? Yes No

List_____

Any problems taking Aspirin, Advil or Aleve?

List_____

PHYSICAL AGENTS

Do you have worse symptoms after exposure to the following: (please circle if yes)

Heat Cold Exercise Drafts Sunlight Weather changes Dampness Air conditioning

HOBBIES

Please list your hobbies. _____

HABITS

Smoking: Yes No Drinking (alcohol): Yes No

Recreational drugs: Yes No

Physician Initials_____ Date_____

PSYCHOLOGICAL FACTORS Please circle any factors you may be experiencing:

Financial problems Nervous tension Work adjustment

Marriage Marital adjustment or status

RASHES FROM CONTACTANTS

Poison Ivy (Sumac, Oak) Other plants Cosmetics Ointments Clothes Metals

HOME

Type of house: Frame Stucco Other

Heating: Hot air Radiators Space heater Other

Age of home _____Years Time resided in _____Years

Floor covering Carpet Wood Moldy smell? Yes No

WORK ENVIRONMENT

Occupation_____

Type of building_____

Air conditioning? Yes No Symptoms at work Better Worse

OCCUPATIONAL HISTORY Any known exposures at your work; now or past_____

MOLDS Do you have worse symptoms after exposure to the following?

Hay, barns, circuses Yes No Raking leaves Yes No

Damp basements Yes No Eating moldy foods Yes No

DANDERS

Please list any pets you have_____

Are you exposed to animals in your work? Yes No

What animals, if any, aggravate your symptoms?_____

MISCELLANEOUS

Please circle the items that seem to worsen your symptoms after exposure.

Cosmetics Perfumes Wave sets Chemicals Paint, Varnish

Insecticides Newspaper Wool/Cotton/Lint

Physician Initials_____ Date_____