Ear, Nose, & Throat Consultants, Inc.

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Allergy Questionnaire

Please complete this questionnaire prior to your allergy testing appointments. Hand the completed questionnaire in to the allergy nurse on the day you are allergy tested.

Name:_____ Date:_____

Please list a maximum of 3 symptoms below that bother you the most:

1. _____

2. _____

3. _____

Have you found any medication that seems to help manage your symptoms?

_____ Nose spray. If so, which one?

_____ Antihistamines. If so, which one?

_____ Decongestants. If so, which one?

_____ Other_____

How long have you had symptoms?

_____ Weeks _____ Months _____Years _____ As long as I can remember

Do you know exactly when you symptoms started?
_____ No

_____ Yes. If so, what do you think happened at that time to trigger symptoms? (move to new area, get new pet, new job, birth of a child _____

Do you have a family history of allergies?

_____ No obvious allergies in my family

If no, does anyone in your immediate family have sinus problems/headaches? _____ Yes _____No

_____ Yes, Who (mother, father, siblings, aunts, uncles) _____

Are symptoms worse:

_____ At home or school. Where in the home / school?_____

_____ At work. What is your occupation?_____

_____ Other location. Please specify _____

Have you always lived in this area? _____ Yes. If not, where else have you lived_____

Are symptoms worse:

_____ Indoors _____ Outdoors _____ Both

Are symptoms worse on rainy days? _____ Yes _____ No

When are symptoms worse?

_____ Spring _____ Summer _____ Fall _____Winter _____Year around with no seasonal difference

When are symptoms worse?

_____ Morning _____Evening _____ During the night _____After meals

Have you ever had allergy testing before?

_____ No, never tested

_____ Yes. If so, approximately when? _____

Did you ever receive allergy injections before?

_____ No

_____ Yes. If so, how long ago? How long did you received injections?_____

Do you have any other health problems that are being treated at this time?

_____ Hypertension _____ Diabetes _____ Thyroid _____ Depression _____ Asthma _____ Other_____

Do you have any animals at home?

_____ No

_____ Yes. If so, what animals?_____

Where do you live?

_____ Country _____ City _____ Apartment _____ House

Age of your apartment or house? _____

If you live in an apartment, is it:

_____ Upstairs apartment _____1st Floor _____2nd Floor _____ Basement apartment

In your apartment or house: Please indicate what you have, check all that apply

_____ Baseboard heat _____Hot air _____ Radiators

_____ Yes, there is carpeting _____ Yes, the bedroom is air conditioned _____ Sleep in basement bedroom

Do you have a basement in your home or apartment?_____

If you have a basement, is the basement finished? _____

Has your house or apartment ever had any flooding?_____

If you have a basement, do you spend much time in the basement?_____

Do you have any hobbies such as wood working or anything that would expose you to unusual substances?

_____

Do you have any food allergies? Please list below:_____

_____

Do some fruits or vegetables make your mouth or throat itch? _____

_____

Have you ever had a headache or increase in nasal or sinus congestion after drinking wine or beer?

_____

Do you have any skin problems? _____

What do you think you are allergic to? _____

_____