Billings Clinic

ALLERGY QUESTIONNAIRE

Patient's Name	Date of Birth
Address	Telephone H W
Clinic No.	Referring Physician

1. INSTRUCTIONS:

Please answer the questions as they relate to the person being evaluated. A complete, accurate record is important in learning about your allergy problem. **Bring this completed form for your first appointment.**

Briefly describe the reason for your allergy visit and what you hope to accomplish:_____

_____

_____

_____

2. PROBLEMS:

Have you ever had the following conditions?

Yes	No	(Check all items)	Age at Onset	Severity			Comments
				Mild	Mod.	Sev.	
		Asthma (Wheezing)					
		Any Other Breathing Problems					
		Sinus Trouble					
		Hay Fever (runny, stuffy, inchy nose; sneezing)					
		Hives or Swelling					
		Eczema or Other Rashes					
		Frequent Infections					
		Food Reactions					
		Drug Reactions					

3. SYMPTOMS:

Have you ever had any of the following: If not, leave blank.

	How many days in the last month	Severity			Circle the Months Most Severe											
		Mild	Mod.	Sev.												
Runny or stuffy nose					J	F	M	A	M	J	J	A	S	O	N	D
Itchy nose					J	F	M	A	M	J	J	A	S	O	N	D
Sneezing					J	F	M	A	M	J	J	A	S	O	N	D
Itchy eyes					J	F	M	A	M	J	J	A	S	O	N	D
Wheezing					J	F	M	A	M	J	J	A	S	O	N	D
Coughing					J	F	M	A	M	J	J	A	S	O	N	D
Wheezing or coughing with exercise					J	F	M	A	M	J	J	A	S	O	N	D
Skin problems					J	F	M	A	M	J	J	A	S	O	N	D
Snoring					J	F	M	A	M	J	J	A	S	O	N	D

4. FOOD REACTIONS:

Have you ever had any symptoms (rash, hay fever, vomiting, gas, cramps, diarrhea, colic as an infant) after the ingestion of any food or liquid? If yes, specify below.

Food	Approximate Date	Symptoms	Can food be eaten?		Date food was last eaten.
			Yes	No	

5. PRECIPITATING FACTORS/ TRIGGERS:

For each item below, check the appropriate square to indicate whether your (or your child's) condition is affected by the following precipitants/triggers.

	Condition Made Worse	Condition Improved	No Change
Cutting or playing in grass, raking leaves	☐	☐	☐
High winds, riding in auto	☐	☐	☐
Other outdoor exposure	☐	☐	☐
Moldy/mildewed areas of items (basement, attic, etc.)	☐	☐	☐
Sweeping, dusting or vacuuming	☐	☐	☐
Smog, smoking or smoke exposure	☐	☐	☐
Tobacco smoke	☐	☐	☐
Air conditioning or heating	☐	☐	☐
Cleaning agents, detergents, ammonia, bleach, soap, conditioner, shaving cream, toothpaste, etc. Specify:_____	☐	☐	☐
Paint lacquer, glue, mothballs, motor fumes, chemicals, fertilizers, insect spray, cooking odors, etc. Specify:_____	☐	☐	☐
Other strong odors, Specify:_____	☐	☐	☐
Exposure to animals (including big game) Specify:_____	☐	☐	☐
"Colds" or viruses	☐	☐	☐
Physical exertion or exercise	☐	☐	☐
Cold weather	☐	☐	☐
Shoveling grain; oats, barley, wheat (combining, haying, swathing, baling)	☐	☐	☐
Other factors_____			
Medications:			
• Antihistamines or cold preparations	☐	☐	☐
• Asthma medications	☐	☐	☐
• Nose drops or spray	☐	☐	☐
• Aspirin	☐	☐	☐
• Other_____			

6. RESIDENCE:

List your past residences with your most recent first. Only city and state required.

City & State	# of Years	Effect on Symptoms (better, worse, no change)
1.		
2.		
3.		
4.		
5.		

7. PREVIOUS ALLERGY EVALUATION AND THERAPY

Have you ever had allergy skin tests?
☐ Yes ☐ No If yes, date_____ Physician's Name_____

Results of these tests: (If possible, please provide us with a copy)

_____

_____

_____

Have you ever received allergy injections?
☐ Yes ☐ No If yes, give dates:_____

Please list **all** medications that you are now taking — name, dosage, number of times a day.
Bring all of these with you for your first appointment.

_____

_____

Please list all medications you have taken for allergies in the past.

_____

_____

_____

8. OTHER MEDICAL PROBLEMS: **Have you ever had any of the following? Answer all items.**

Check all items	Yes	No
Frequent Headaches	☐	☐
Frequent Nosebleeds	☐	☐
Nasal Polyps	☐	☐
Operation on Sinuses	☐	☐
Sinus X-Rays	☐	☐
Ear Infections number past year_____	☐	☐
Hearing Problems	☐	☐
Glaucoma	☐	☐
Sleep Disorder	☐	☐
Pneumonia, number past year_____	☐	☐
Coughed Up Blood	☐	☐
Tuberculosis	☐	☐
Chest X-Ray	☐	☐
Heart Trouble	☐	☐
High Blood Pressure	☐	☐
Frequent Heartburn	☐	☐
Diabetes	☐	☐
Prostate, Kidney or Bladder Trouble	☐	☐
Liver Trouble (e.g. Hepatitis)	☐	☐
Frequent Diarrhea	☐	☐
Abdominal Pain	☐	☐
Bedwetting	☐	☐
Recurrent Yeast Infections	☐	☐
Stomach Ulcer	☐	☐
Other_____	☐	☐
_____		

9. HOSPITALIZATIONS/SURGICAL PROCEDURES

(Including Tonsillectomy, Adenoidectomy, PE Tubes)

List most recent	Reason	Date
1.		
2.		
3.		
4.		
5.		

10. FAMILY HISTORY

Do any members of your family have a history of allergy?

	Yes	No	If yes, list all relatives (e.g. parents, brothers & sisters, children, aunts, uncles, grandparents, etc.)
Asthma			
Hay Fever			
Eczema			
Hives			
Swelling			
Frequent Pneumonia			
Headaches			
Other Allergies			

Is there a family history of any other illnesses?

	Yes	No	If yes, list all relatives.
Emphysema or Other Lung Disease			
Cystic Fibrosis			
Tuberculosis			
Thyroid Disease			
Glaucoma			
Diabetes			
Other			

11. ENVIRONMENTAL SURVEY

Where do you live? (city or rural)	Number of indoor plants Number in bedroom
Age of house: # years lived there	House construction (brick, wood, etc.)
Are any rooms damp or musty?	Do you have: (a) an air cleaner? (b) an air humidifier?
Type of heating (forced air, steam, spaceheater baseboard, electric, etc.)	Type of air conditioning (central, window, etc.)

Type of Carpet (wool, synthetic, jute)	Bedrooms	Living Room	Den	Dining Room	Kitchen	Baths
	carpet					
And Pad (rubber, ozite, hair)	pad					

How old is your: Pillow? How old is your: Mattress?	Do you have any: Stuffed furniture? Do you have any: Feather comforters?
Is your pillow: ☐ feather ☐ foam rubber ☐ dacron ☐ other_____ ☐ encased in plastic	Is your mattress: ☐ foam rubber ☐ cotton ☐ innerspring & cotton ☐ waterbed ☐ encased in plastic ☐ other_____

What kinds of grasses, shrubs and trees are in the immediate vinicity of your house?

Do you have pets? List number and kind (dog, cat, birds, horses, etc.) Do your pets spend time indoors? ☐ Yes ☐ No In patients bedroom? ☐ Yes ☐ No

What type of work do you or your parents do?

Are you exposed to anything at work that might aggravate your condition? Which things?

Have you missed any time from work or school because of your allergies? How much time?

Do you have any other exposures from hobbies, recreational activities, etc.?

If you are a farmer/rancher, what crops/animals do you raise?

Does your child go to a day care center or babysitter? ☐ Yes ☐ No Animals there? ☐ Yes ☐ No # of Children_____

12. SMOKING

Have you ever smoked? ☐ Yes ☐ No If yes, how many years?_____

Do you presently smoke? ☐ Yes ☐ No When did you stop?_____

Average cigarettes per day at highest point?_____ If you still smoke, do you think you could stop? ☐ Yes ☐ No

Which other family members now smoke?

_____

_____

_____

BRING THIS COMPLETED FORM WITH YOU FOR YOUR FIRST APPOINTMENT. THANK YOU.

Allergy Patient Instructions

Before Your Appointment

If you take Antihistamines (Benadryl, Claritin, Zyrtec, Hydroxyzine, etc.), Vitamin C, Beta Blockers and/or Antidepressants, please contact our office immediately for further instructions on when you must discontinue use of these products before your appointment. Avoid Dramamine, Bonine or other medications for motion sickness. (You may continue taking any Asthma Medications.)

The Day of Your Appointment

Please refrain from wearing perfume or scented products the day of your appointment. Also refrain from tanning and be careful not to get sunburn 7 days prior to your appointment.

If you are from out of town, please make arrangements to spend the night. Testing normally takes two days to complete. If you have any questions, please call us at 238-2662 or 1-800-332-7156.