**Allergy Questionnaire**

**Part 1: Please answer only the sections that apply to you**

Age: ________  Sex: □ Male □ Female  Birthplace: ________________  Years in Northwest: ______

Your main concerns: ________________________________________________________________

Complete this section only for: NOSE / THROAT / EARS / EYES / HEAD SYMPTOMS  *If none, skip to next section*

1) Check all that apply and circle the ones that bother you the most:

<table>
<thead>
<tr>
<th>Nose</th>
<th>Throat</th>
<th>Ears</th>
<th>Eyes</th>
<th>Head</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ itchy nose</td>
<td>□ sore throat</td>
<td>□ itchy ears</td>
<td>□ itchy eyes</td>
<td>□ headache</td>
</tr>
<tr>
<td>□ sneezing</td>
<td>□ itchy throat or palate</td>
<td>□ plugged ears</td>
<td>□ watery eyes</td>
<td>□ facial pressure</td>
</tr>
<tr>
<td>□ congestion</td>
<td>□ throat clearing</td>
<td>□ ringing</td>
<td>□ red eyes</td>
<td>□ pain</td>
</tr>
<tr>
<td>□ decreased smell/taste</td>
<td>□ cough</td>
<td>□ hearing loss</td>
<td>□ dry/irritated eyes</td>
<td>□ discharge</td>
</tr>
<tr>
<td>□ snoring</td>
<td>□ hoarseness</td>
<td>□ post-nasal drainage –</td>
<td>□ swollen lids</td>
<td></td>
</tr>
<tr>
<td>□ runny nose - if yes, is the nasal discharge: □ clear □ colored</td>
<td>□ if yes, is the drainage: □ clear □ colored</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

2) When did your symptoms first begin? __________________________  When, if so, did they get worse? __________________________

3) Are your symptoms: □ seasonal* □ all year long □ all year long, with seasonal worsening*

* Circle the worst months: Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec

4) Check the things that make your symptoms worse:

<table>
<thead>
<tr>
<th>Irritants</th>
<th>Weather</th>
<th>Medicine</th>
<th>Allergens</th>
<th>Location</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ smoke</td>
<td>□ cold air</td>
<td>□ aspirin</td>
<td>□ grass</td>
<td>□ outdoors</td>
<td>□ _______</td>
</tr>
<tr>
<td>□ air pollution</td>
<td>□ rapid temperature change (e.g. going from cold outdoors to indoor heat)</td>
<td>□ non-steroidal anti-inflammatory agents (e.g. Motrin, Advil, Alleve)</td>
<td>□ dust or vacuuming</td>
<td>□ indoors</td>
<td></td>
</tr>
<tr>
<td>□ fumes or car exhaust</td>
<td>□ change (e.g. going from cold outdoors to indoor heat)</td>
<td></td>
<td>□ damp or musty area</td>
<td>□ daycare</td>
<td></td>
</tr>
<tr>
<td>□ strong odors or perfumes</td>
<td>□ change</td>
<td>□ animals, if so specify: _______</td>
<td>□ nasal polyps</td>
<td>□ home</td>
<td></td>
</tr>
<tr>
<td>□ exhaust</td>
<td>□ change</td>
<td></td>
<td></td>
<td>□ school</td>
<td></td>
</tr>
<tr>
<td>□ strong odors</td>
<td>□ change</td>
<td></td>
<td></td>
<td>□ work</td>
<td></td>
</tr>
</tbody>
</table>

5) Have you had any of the following problems or procedures: *If yes, specify □ Yes* □ No

□ frequent ear infections  □ PE tubes  □ nasal or sinus surgery  □ nasal polyps
□ broken nose  □ frequent sinus infections (how many in a year? ________)

Complete this section if: ALLERGIC REACTION TO A STING, DRUG, FOOD or other SUBSTANCE  *If none, skip to next section*

If more than one reaction: answer the same questions for each reaction on a separate page

1) What did you react to?

If stung, where on your body were you stung? __________________________

2) When did the reaction occur? (date and time of day) __________________________

3) Length of time from exposure (or sting/injection) until onset of symptoms: __________________________

4) How long did your symptoms last? __________________________

5) Briefly describe the reaction: ________________________________________________________________

6) Please check any of the following symptoms you had with your reaction:

□ shortness of breath  □ tongue swelling  □ hoarseness or change in voice
□ dizziness or loss of consciousness  □ wheezing or chest tightness  □ throat tightness or trouble swallowing
□ flushing  □ abdominal cramping, diarrhea or vomiting

7) Did you get medical attention? □ Yes* □ No

* If yes, was it from: □ Emergency Room  □ Urgent Care  □ Clinic  □ 911/Medics

8) Treatment (if any) you received: ________________________________________________________________

9) Do you have a current EpiPen? □ Yes □ No
Complete this section only for: CHEST or ASThma SYMPTOMS  *If none, skip to next section

1) Check all that apply and circle the ones that bother you the most:
   □ shortness of breath     □ wheezing
   □ chest pain or tightness  □ coughing up blood
   □ recurrent or chronic cough – if yes, is the cough: □ wet/productive    □ dry

2) When did your symptoms first begin? ____________  When, if so, did they get worse? ____________

3) Are your symptoms:  □ seasonal*  □ all year long  □ all year long, with seasonal worsening?
   * Circle worst months: Jan  Feb  Mar  Apr  May  Jun  Jul  Aug  Sep  Oct  Nov  Dec

4) How often do you have symptoms? □ 2 or less times a week  □ once a day
   □ 3–6 times a week  □ throughout the day

5) Do these symptoms disturb your sleep?  □ Yes*  □ No
   *If yes, how often?  □ 2 or less times a month  □ 3–4 times a month  □ 2–6 times a week  □ every night

6) Do your symptoms ever interfere with exercise or daily activities?  □ Yes*  □ No
   * If yes, what activity? __________________________

7) Have your symptoms forced you to miss work or school? (Circle which one)  □ Yes*  □ No
   * If yes, how many times in the past 12 months? ____________

8) Have your symptoms caused you to go to the Emergency Room or Urgent Care?  □ Yes*  □ No
   * If yes, how many visits in the past 12 months? ____________

9) Have your symptoms caused you to be admitted overnight to the hospital?  □ Yes*  □ No
   * If yes, how many times?    Were you ever in the Intensive Care Unit?  □ Yes  □ No
   Have you been intubated or on a ventilator? □ Yes  □ No

10) Have you ever needed treatment with an oral or injectable steroid? (e.g. prednisone)  □ Yes*  □ No
    * If yes, what was your last course of steroids? __________________________

11) Check the things that make your chest symptoms worse:

<table>
<thead>
<tr>
<th>Irritants</th>
<th>Infections</th>
<th>Weather</th>
<th>Medicine</th>
<th>Allergens</th>
<th>Location</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>smoke</td>
<td>colds/sinus infections</td>
<td>cold air weather changes</td>
<td>aspirin/anti-inflammatory agents</td>
<td>grass/dust/vacuuming</td>
<td>outdoors</td>
<td>exercise/emotion/stress</td>
</tr>
<tr>
<td>fumes/car exhaust</td>
<td>or flu/infections</td>
<td>heat</td>
<td>(e.g. Motrin, Advil, Aleve)</td>
<td>damp/musty areas</td>
<td>indoors</td>
<td>laughing</td>
</tr>
<tr>
<td>air pollution</td>
<td>strong</td>
<td></td>
<td></td>
<td>animals, if yes, specify:</td>
<td>home</td>
<td>other:</td>
</tr>
<tr>
<td>odors or perfumes</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>daycare</td>
<td></td>
</tr>
</tbody>
</table>

12) Have you ever had pneumonia?  □ Yes*  □ No  * If yes, how many times? ____________

13) Have you had a chest X-ray since your symptoms began?  □ Yes*  □ No  * If yes, when? ____________

14) Do you have symptoms of heartburn or acid reflux?  □ Yes*  □ No  * If yes, how often? ____________

If you've been prescribed albuterol or have asthma, please answer the following questions:

1) How many puffs of albuterol do you use per day? ____________
2) How many canisters of albuterol do you use each month? ____________
3) Do you use a spacer with your inhalers?  □ Yes  □ No
4) Do you monitor your peak flows?  □ Yes*  □ No
   * If yes, what is your personal best peak flow? ____________
   * What has been the range of your peak flow readings over the past 2 weeks? ____________

Complete this section only for: ECZEMA  *If none, skip to next section

1) When did your eczema first begin? ____________  When, if so, did it get worse? ____________

2) What parts of your body are most affected? __________________________

3) Are your symptoms:  □ seasonal*  □ all year long  □ all year long, with seasonal worsening*
   * Circle worst months: Jan  Feb  Mar  Apr  May  Jun  Jul  Aug  Sep  Oct  Nov  Dec

4) Check the things that make your eczema worse:

<table>
<thead>
<tr>
<th>Irritants</th>
<th>Allergens</th>
<th>Foods</th>
<th>Other:</th>
</tr>
</thead>
<tbody>
<tr>
<td>soaps</td>
<td>dust/mold</td>
<td>milk/nuts</td>
<td>Infection</td>
</tr>
<tr>
<td>detergents</td>
<td>pollen</td>
<td>wheats/eggs</td>
<td></td>
</tr>
<tr>
<td>wool</td>
<td>animals:</td>
<td>soy/peanuts</td>
<td></td>
</tr>
<tr>
<td>heat</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

DO NOT SCAN THIS QUESTIONNAIRE

Continued on next page
Complete this section only for: HIVES or SWELLING  *If none, skip to next section

1) What is your main problem?  □ hives  □ swelling  □ hives and swelling
2) What parts of your body are affected? ________________________________
3) When did your symptoms first begin? ______________ When was your last outbreak? ______________
4) On the average, how long does each outbreak last? ______________
5) How often do outbreaks occur?  □ daily  ___ times a week  ___ times a month  ___ times a year
6) If you have hives, how long does each individual hive last?  □ less than 24 hours  □ more than 24 hours
7) Check any symptoms you have with hives:  □ itching  □ burning  □ tingling  □ pain  □ bruising
   Symptoms worse in the:  □ spring  □ summer  □ autumn  □ winter
   Symptoms worse in the:  □ morning  □ afternoon  □ evening  □ night
   Symptoms worse during:  □ weekdays  □ weekends  □ menstrual cycle
9) During an outbreak, do you have any of the following symptoms?  □ Yes* □ No * If yes, check box.
   □ shortness of breath  □ flushing  □ tongue swelling  □ throat tightness or trouble swallowing
   □ wheezing or chest tightness  □ hoarseness or change in voice  □ dizziness or loss of consciousness
   □ joint pain  □ fever  □ swollen glands  □ diarrhea, vomiting or abdominal pain
10) Check the things that make your symptoms worse:

<table>
<thead>
<tr>
<th>Exposure to:</th>
<th>Medicines</th>
<th>Allergens</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>exercise</td>
<td>aspirin</td>
<td>grass</td>
<td>emotion or stress other: ________</td>
</tr>
<tr>
<td>cold air</td>
<td>non-steroidal</td>
<td>dust or vacuuming</td>
<td></td>
</tr>
<tr>
<td>sunlight</td>
<td>anti-inflammatory agents</td>
<td>wooded areas</td>
<td></td>
</tr>
<tr>
<td>heat (shower/bath)</td>
<td>(e.g. Motrin, Advil, Aleve)</td>
<td>damp or musty area</td>
<td></td>
</tr>
<tr>
<td>rubbing or scratching</td>
<td>ACE inhibitors</td>
<td>latex (balloons, condoms, dental work, latex gloves)</td>
<td></td>
</tr>
<tr>
<td>vibration (mowing lawn, motorcycling)</td>
<td>(e.g. lisinopril)</td>
<td>animals, specify:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>other medicines:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

11) Check the box if the following events happened soon before your symptoms started:
   □ mononucleosis  □ jaundice or hepatitis  □ sore throat or strep throat  □ sinus infection
   □ swollen lymph glands  □ urinary tract infection  □ toothache or gum infection  □ bee sting
   □ pneumonia  □ thyroid problems  □ ulcers or gastritis
   □ fungal infection of skin, scalp, or nails  □ impetigo or skin infection
   □ transfusion  □ immunization, specify: __________________________________________
   □ recent move from another area; from where? ______________________________________
   □ job change, specify: __________________________________________________________
   □ change of residence  □ foreign travel, where? ______________________________________
   □ other: __________________________________________________________

Part 2: Please answer all of the remaining questions

Medicines
List all prescription and over-the-counter medicines you’re currently taking that you do not receive through Group Health. Include oral, inhaled, injected, drops, sprays, suppositories, creams and ointments.

<table>
<thead>
<tr>
<th>Name of medicine</th>
<th>Strength (if known)</th>
<th>Dose and number of times taken per day</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Attach separate list if necessary.

Allergy History
1) Have you had previous allergy skin testing?  □ Yes* □ No * If yes, when? __________
2) Have you ever received allergy shots?  □ Yes* □ No * If yes, specify the years you received them:
   From _______ to _______  Additional years: From _______ to _______  From _______ to _______
   Were the shots helpful?  □ Yes  □ No  Did you have any bad reactions?  □ Yes  □ No
3) Do you have allergies to any foods?  □ Yes* □ No * If yes, specify:
   Name of food  Allergic reaction(s)  Approximate date of reaction(s)
   ____________________________________________  ____________________________
   ____________________________________________  ____________________________
   ____________________________________________  ____________________________

DO NOT SCAN THIS QUESTIONNAIRE
page 3 of 4  Continued on next page
Past Medical History

1) Check the box if you've had any of the following:
   □ glaucoma  □ cataracts  □ depression  □ high blood pressure
   □ diabetes  □ tuberculosis  □ positive TB test  □ peptic (stomach) ulcer
   □ AIDS or HIV  □ kidney disease  □ aseptic necrosis  □ osteoporosis  □ heart problems
   □ other significant medical problems: ____________________________

2) Please list all surgeries and hospital stays: (followed by approximate date)

   __________________________________________
   __________________________________________
   __________________________________________

3) Have you ever smoked?  □ Yes*  □ No * If yes, specify.
   Are you: □ a current smoker?  □ a past smoker?  Quit date: ____________
   What and how long did you smoke?  □ cigarettes: ____ years  Packs per day: ____________
   □ cigars: ___ years  □ pipe: ___ years

4) Does anyone in your home smoke?  □ Yes*  □ No * If yes, specify.
   □ mother  □ father  □ spouse or partner  □ son  □ daughter
   □ brother  □ sister  □ roommate  □ other: ____________________________

Family History

Please place a check mark for each relative with the following medical problems:
* If more than one relative has the same medical problem, place a check mark for each one.

Example: 2 brothers with asthma:

<table>
<thead>
<tr>
<th>Medical Problem</th>
<th>Mother</th>
<th>Father</th>
<th>Brother</th>
<th>Son</th>
<th>Daughter</th>
<th>Grandmother</th>
<th>Grandfather</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asthma</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emphysema</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nasal allergy</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sinus problems</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eczema</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Environmental History

1) What is/was your occupation or, if you are still a student, your grade in school? ________________________
2) What are your hobbies? ____________________________
3) How long have you lived at your present location? _____ years
4) Location: □ downtown  □ urban  □ suburb  □ rural/country
5) Type of home: □ house  □ apartment/condo  □ houseboat  □ mobile home  □ other: ______
6) Where do you live? (City, town, city neighborhood, or nearest city)? __________________________________________________________________
7) Type of heating: □ radiant  □ forced air  □ heat pump  □ wood burning stove  □ pellet stove  □ other: ______
8) Air conditioning: □ none  □ central  □ window units
9) Air filter: □ HEPA  □ electrostatic
10) Floor:  Bedroom: □ carpeting  □ wood/laminate  □ tile  □ cement  □ other: ____________
     Family room: □ carpeting  □ wood/laminate  □ tile  □ cement  □ other: ____________
11) Mattress: □ regular  □ foam  □ air mattress  □ waterbed  □ futon  □ other: ____________
12) Pillow: □ synthetic  □ foam  □ down  □ feather  □ cotton  □ other: ____________
13) Comforter: □ none  □ down  □ synthetic  □ feather  □ other: ____________
14) Do you have zippered dustmite allergy covers (encasements)? □ Yes*  □ No * If yes, what item is covered?
    □ pillows  □ mattress  □ comforter  □ box springs
15) Do you have any pets? □ Yes*  □ No * If yes, check all that apply and how many of each animal.
    □ cat(s) #____  □ dog(s) #____  □ bird(s) #____  □ guinea pig(s) #____
    □ gerbil(s) #____  □ hamster(s) #____  □ rabbit(s) #____  □ other: ____________
    Circle all pets that live in or have access to your (or the patient’s) bedroom.
16) Do you have a mold or mildew problem in your home? *If yes, is it a □ minor problem? □ major problem?
    Where is it? □ bathroom  □ basement  □ kitchen  □ window sills  □ other: ____________________________

Thank you