KAISER PERMANENTE®

Allergy Questionnaire

Name ______________________________

Member ID Number ____________________

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:

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

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:

Irritants	Weather	Medicine	Allergens	Location	Other
☐ smoke ☐ air pollution ☐ fumes or car exhaust ☐ strong odors or perfumes	☐ cold air ☐ rapid temperature change *(e.g. going from cold outdoors to indoor heat)*	☐ aspirin ☐ non-steroidal anti-inflammatory agents *(e.g. Motrin, Advil, Aleve)*	☐ grass ☐ dust or vacuuming ☐ damp or musty area ☐ animals, if so specify: _______ ________________	☐ outdoors ☐ indoors ☐ daycare ☐ home ☐ school ☐ work	☐ ________ ________ ________ ________ ________ ________

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

DO NOT SCAN THIS QUESTIONNAIRE

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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, when was your last course of steroids? ________________________

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

Irritants	**Infections**	**Weather**	**Medicine**	**Allergens**	**Location**	**Other**
smoke fumes/car exhaust air pollution strong odors or perfumes	colds or flu sinus infections	cold air weather changes heat	aspirin non-steroidal anti-inflammatory agents *(e.g. Motrin, Advil, Aleve)*	grass dust/vacuuming damp or musty areas animals, If yes, specify: ___________	outdoors indoors home daycare school work: __________	exercise emotion/ stress laughing other: _________

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**:

Irritants	**Allergens**	**Foods**	**Other:**
soaps detergents wool heat tight clothing cosmetics sun	dust pollen animals: _________ mold	milk wheat nuts eggs soy peanuts other: ____________________	Infection _____________

DO NOT SCAN THIS QUESTIONNAIRE

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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
8) Check all that apply: Symptoms worse in the: ☐ spring ☐ summer ☐ autumn ☐ winter
Symptoms worse in the: ☐ morning ☐ afternoon ☐ evening ☐ night
Symptoms worse in the: ☐ outdoors ☐ indoors ☐ home ☐ school ☐ daycare ☐ work
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**:

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

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 Kaiser Permanente.** Include oral, inhaled, injected, drops, sprays, suppositories, creams and ointments.

Name of medicine	Strength (if known)	Dose and number of times taken per day

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

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Past Medical History

1) Check the box if you've had any of the following:
☐ glaucoma ☐ cataracts ☐ depression ☐ high blood pressure
☐ diabetes ☐ tuberculosis ☐ positiveTB 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:

Medical Problem	*Mother*	*Father*	*Brother*
Asthma			✓✓

Medical Problem	Mother	Father	Brother	Sister	Son	Daughter	Grandmother	Grandfather
Asthma								
Emphysema								
Nasal allergy								
Sinus problems								
Eczema								

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 <u>zippered</u> 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 <u>and</u> how many of each animal.*
☐ cat(s) #___ ☐ dog(s) #___ ☐ bird(s) #___ ☐ guinea pig(s) #___
☐ gerbil(s) #___ ☐ hamster(s) #___ ☐ rabbit(s) #___ ☐ other: _________________
<u>**Circle**</u> 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? ☐ Yes* ☐ No *If yes, is it a ☐ minor problem? ☐ major problem?
Where is it? ☐ bathroom ☐ basement ☐ kitchen ☐ window sills ☐ other: ______________________

Thank you