GENERAL ALLERGY QUESTIONNAIRE

INSTRUCTIONS: **Carefully complete ALL FOUR SIDES. Any item unmarked is considered a negative response to the question. Relate your answers to your own experiences, not to previous advice or skin tests. ALL INFORMATION WILL BE CONSIDERED CONFIDENTIAL.**

Name _____ Age Sex Race / Ethnicity

Florida Primary Care Dr name: _____ **Referring Dr:** _____

Names of ENT Dr's you have seen: _____ **Pulmonologist:** _____

Preferred Local pharmacy (Phone & Street Name): _____

What is your **chief complaint?** _____ When did it **first begin** _____(Year)
Recent **flare-up** _____(Month) _____(Year)
How often does it occur _____ (daily, weekly, etc.) **Worst at:** ___night ___day ___early morning

How long does it last _____ (hours, days, etc.) **Rapid onset attacks:** ___yes ___no

Circle months: January February March April May June _____All
July August September October November December _____None

Are you worse on **certain days of the week?** Specify _____ _____None

Is it **worse** at: ___home ___school ___work ___sports/hobbies other: _____ _____None

During the **last year** which would you say characterizes your condition:
___On and off ___Daily ___Progressive ___Incapacitating ___Can't sleep

CIRCLE ANYTHING THAT AGGRAVATES YOUR PROBLEM:

IRRITANTS: Odors (household chemicals, cooking, toiletries, cleaning agents), Smoke, Motor fumes, Paint, Insect spray/repellent, Fertilizers, Room deodorants, Other: _____ _____None

FOOD SYMPTOMS: Milk, Cheese, Ice Cream, Seafood, Chocolate, Whiskey, Wine, Beer, Juice, Corn, Pork, Eggs, Spices, Tomatoes, Strawberries, Nuts, Peanuts, Wheat products, Very cold liquids, MSG, Food Dyes, Chemical preservatives, Other: _____ _____None

PETS __Dogs, __Cats, __Birds, __Horses, __Hamsters, __Rabbits, __Gerbils, __Guinea pigs _____None

WEATHER EXTREMES: Heat, Cold, Humid, Dry, Pollution, Rain, Change in temperature, Change in seasons, Wind or drafts, Evening dampness, Change in barometer _____None

CONTACTANTS: (Touch) Poison ivy, Cut grass, Cut flowers or shrubs, Christmas trees, Fiberglass, Feather Pillows, Latex or rubber gloves, Insect sprays, Sun block, Jewelry, Other chemicals: _____ _____None

OCCUPATION: List your present / pre-retirement **occupation(s):** _____
Occupational exposure: stress, tension, odors, dusts, smoke, fumes chemical sprays, fiberglass, extremes of temperature or humidity, latex gloves, strong soaps _____None

NOCTURNAL: At **3-4 A.M.** do you have …
___ Hacky cough ___ Post nasal drip ___ Awaken with startle _____None
___ Wheeze ___ Heavy snoring ___ Briefly stop
___ Chest tightness ___ Heartburn breathing

Attn. Coding Auditor: As per E/M guidelines, any items left encircled, unchecked, or blank indicate a pertinent negative entry. 100

PRESENT ILLNESS and REVIEW OF SYMPTOMS

CIRCLE YOUR SYMPTOMS:

GENERAL: Chills, fever, poor appetite, fatigue, irritability, loneliness, inability to think clearly, poor memory, worn out, can't concentrate, trouble getting to sleep, restless sleep, awaken early, fall asleep during the day. _____None

HEADACHE: **WHERE** □ Top of head, back of neck, around eyes, temples: __right __left __both
WHEN □ Day, night, both … upon wakening, after sleeping too long
TYPE □ Aching, throbbing, pressure, sharp, dull, combined with vomiting, better with sleep, spots before eyes, worse when bending over, teeth hurt
CAUSE □ Migraine, sinus, tension, cluster, caffeine, hormonal, TMJ, arthritis
FREQUENCY □ _____ Times per day/ week/ month _____None

SKIN: Rash, hives, swelling, eczema, blisters, dry, itching, burning, stinging, redness, excessive Sweating, dandruff, nail or foot fungus _____None

EYES: **GENERAL** □ Blurring of vision, pain, gritty feeling, dry feeling _____None
WHITES □ Itching, redness, burning, watering, morning discharge _____None
LIDS □ Swelling, itching, redness, flaking skin, dark circles under eyes _____None

EARS: Fullness, popping, itchiness, dizziness, earache, ringing or other noises, deafness …
# of ear infections in the last year: _____ _____None

NOSE: Trouble smelling, stuffiness, dripping, sniffing, rubbing, sneezing, snoring, polyps, post-nasal drip, bleeding, deviated septum …# of sinus infections in the last year: ___ _____None

MOUTH: Trouble tasting, swollen, sore, itching, burning, coated, spots on tongue, teeth hurt _____None

THROAT: Frequent throat clearing, lump in throat, tight throat, hoarseness, weak voice, itching of roof, bad breath, repeated tonsillitis, morning sore throats, trouble swallowing, mouth breathing _____None

MUCUS: **COLOR** □ clear, opaque, yellow, green, brown, bloody _____None
CHARACTER □ constant throat clearing, causes gagging, can't sleep, choking episodes _____None

COUGH: **CHARACTER** □ Deep, dry, tickle, hacky, loose _____None
TIMING □ Daytime, evening, interrupts sleep, exertional, emotional, when talking, when lying down _____None

CHEST: Breathless, wheeze, chest tightness, chest rattle, cough then wheeze, awaken with startle, trouble walking or climbing, need to sigh a lot, weak voice when breathless, wheeze with menses
visits in the last year: _____ER _____Hospital admissions _____None

STOMACH: Heartburn, hiatal hernia, frequent use of antacids, trouble swallowing, fullness in chest after eating, episodes of bile liquid in mouth, nausea, vomiting, gas, cramps, gallstones, belching, diarrhea, mucus in stool, soiling _____None

EMOTIONS: Tension, worries, depression, financial problems, sexual problems, problems at work or school, always tired, cry easily, feel frustrated, impatient … _____None
If patient is a child … Emotional impact of ___parental discord ___sibling problem
Marital or family relationship problems: afraid for your safety… the children's safety… verbal abuse … physical abuse _____None

OTHER: WOMEN: Are your symptoms worse with menstral cycle? Yes / No
MEN: Do you have an **enlarged prostate** or problems passing your urine? Yes / No
Do you use eye drops for **glaucoma** of the eyes? Names: _____ Yes / No
Have you ever had **low thyroid** or surgery of the thyroid gland? Yes / No

PAST MEDICAL/SURGICAL, SOCIAL AND FAMILY HISTORIES

Childhood: Breast fed, bottle fed, colic, croup, hives, eczema, frequent colds, recurrent earaches, tonsillitis, asthma, bronchitis, food allergies, headaches, hyperactive, learning disability, other:_____

Medical conditions **for which you've ever had:** diabetes, high blood pressure, stroke, heart condition, hiatal hernia, gerd/reflux, TB, pneumonia, COPD, hypothyroid, hashimotos, arthritis, glaucoma, cancer, HAE, immunodeficiency, hypoglycemia, sleep apnea, anxiety, depression, osteoporosis, learning disability, **other:**_____

Surgeries & Year performed: _____ _____None

Drug Allergy & Reaction: Penicillin, Erythromycin, Sulfa, Aspirin, Iodide, X-Ray dye, Novocain, Codeine
Other:_____

Medications/Supplements current: _____ _____None

_____

_____ **CPAP: yes no / Oxygen: yes no**

Last ***Flu shot:*** _____(mo/yr) Last ***Pneumonia shot*** _____ ***(mo/yr)***

Last **Labs:** _____(mo/yr) with Dr._____ Last **CT:** sinus/chest _____(mo/yr) with Dr._____

Last **Cxr:** _____(mo/yr) with Dr._____ Last **skin biopsy** _____mo/yr) with Dr._____

Drug Usage: Marijuana, heroin, cocaine, body building steroids, recreational drugs ***How often?*** _____ _____None

Menses: Last period: _____(Date) Are you ***pregnant?*** Yes / No

Tobacco: (circle) Cigarettes, cigars, pipe ***Still Smoke:*** Yes / No ***Inhale:*** Yes / No

Number per day _____ ***Year started*** _____ ***Year stopped*** _____ ***How many years*** _____ _____Never

Are you ***exposed to smoke:*** ___ at home ___ at work ___ socially

Marital Status: (give parents' status if patient is a child)

Married, re-married, single, cohabitating, separated, divorced, widowed, gay / lesbian

Number of children: _____ Any adopted: ___ yes ___ no

If patient is child: ___ One residence _____ Time split between two parent's homes

Education level: _____

Alcohol Intake: Average per day _____ Type: ___Liquor _____Beer ___Wine _____None

Hobbies: _____

Family Illnesses	***Self***	***Father***	***Mother***	***Brothers***	***Sisters***	***Children***	***Grand-parents***
Migraine							
Hives							
Eczema							
Hay Fever							
Sinus Condition							
Glaucoma							
Emphysema							
Asthma							
Cystic Fibrosis							
Tuberculosis							
Diabetes							
Thyroid Disease							
Heart Attack							
Stroke							
High Blood Pressure							
Cancer							
Other							

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ENVIRONMENTAL and ALLERGY HISTORIES

How long have you lived ***in this area of Florida*** _____(years)
If a part-time resident, where is your ***other home*** (state/country) _____

Type of Dwelling → Condo, apartment, cement block house, wood house, dormitory, mobile home, boat
Fla home: ***Year Dwelling built:*** _____ ***Move in year:***_____
Out of state home: ***Year Dwelling built:*** _____ ***Move in year:***_____

HOW MANY OF EACH PET DO YOU HAVE:__Dogs, __Cats, __Birds, __Hamsters, __Rabbits, __Gerbils, __Guinea pigs, __Horses ___None My pets come: ___indoors ___strictly outdoor pets
Does your pet have fleas: Yes___ No___ Has pet had mites? Yes___ No___

	Fla.home	OOS home	
Pillow: Feather, foam, dacron / polyester,	_____	_____	(year purchased)
Mattress: Foam, inner spring, waterbed, air mattress, sleep number	_____	_____	(year purchased)
Mattress Topper / Bedpad: Feather, foam, dacron / polyester	_____	_____	(year purchased)
Blanket: Cotton, polyester, wool, feather comforter	_____	_____	(year purchased)
Flooring: Carpeting in: ___***Bedroom*** ___***Livingroom***	_____	_____	(year purchased)

A/C: ***Central Air*** ___yes ___no ***Wall unit*** ___yes ___no
Ceiling fans: ___yes ___no

Previous Allergy Evaluation: When: _____ (approximate year)
Allergist's name and city: _____
Allergies discovered at that time: _____

Are you ***now*** receiving ***allergy injections***? Yes / No Ever had an ***adverse reaction to allergy shots***? Yes / No
Injection contents _____
When was your ***last injection***? _____ ***How long*** have you been receiving them? _____(years)
Miscellaneous:
Have you ever had ***collagen, silicone implants*** or ***metal joint*** parts surgically placed in your body? _____None
Where in body / When: _____

Insect bites or stings: Large local swelling, itching all over body, rash all over body, weakness, sweating, shortness of breath, stuffy nose, wheezing, swollen eyes _____None

PATIENT SIGNATURE:_____

PHYSICIAN'S ANALYSIS OF DATA:

Dr. Signature:_____ Med Asst. Initials_____ Date:_____