FRANCE AVENUE FAMILY PHYSICIANS
ALLERGY QUESTIONNAIRE

Patient's Name:_____ Age:_____ Date:_____

Referred By:_____ Time in current area:_____

List past and current Allergy/Asthma medicines, including over the counter

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Past Medical History:

Have you ever used an inhaler, even as a child? YES / NO

Do you have a history of:

Eczema (atopic dermatitis): YES / NO Asthma: YES / NO Allergies: YES / NO

Heartburn (GERD): YES / NO Hives (urticaria): YES / NO

Does anyone in your family have:

Eczema (atopic dermatitis): YES / NO Asthma: YES / NO Allergies: YES / NO

Heartburn (GERD): YES / NO Hives (urticaria): YES / NO

Have you ever had anaphylaxis (shock, hives, extensive swelling, shortness of breath)? YES / NO

Check the symptoms that trouble you

_____ Sneezing	_____ Stuffy nose	_____ Trouble breathing	_____ Hives
_____ Watery eyes	_____ Drainage in throat	_____ Wheezing	_____ Rash
_____ Itchy eyes	_____ Frequent sore throat	_____ Tightness in chest	_____ Asthma
_____ Itchy ears	_____ Nasal polyps	_____ Frequent cough	_____ Bronchitis
_____ Itchy nose	_____ Sinus/nose surgery	_____ Wheezing w/ exercise	_____ Pneumonia
_____ Runny nose	_____ Itchy roof of mouth	_____ Frequent headaches	_____ Broken nose
_____ Sinus infections	_____ Puffy swollen eyes	_____ Frequent earaches	

_____ Other _____

What symptoms bother you the most?

What seasons are you bothered? (Circle all that apply) Spring Summer Autumn Winter

Where are your symptoms worse? (Circle) Indoors or Outdoors

Home or Work or School

How old were you when your symptoms began? _____ Where were you living? _____

Do you smoke? YES / NO Do you live with a smoker? YES / NO

(over)

Check the things that trigger your allergy or asthma symptoms:

_____ Weather changes	_____ Cats	_____ Exercise
_____ Dampness	_____ Dogs	_____ Anger/stress
_____ Odors/perfumes	_____ Other animals	_____ Coughing/laughing
_____ Smoke/tobacco	_____ Grass/mowing	_____ Colds/respiratory infections
_____ Dust	_____ Weeds	_____ Cold air
_____ Cosmetics/aerosols	_____ Trees	_____ Molds

_____ Foods/drinks (Which?) _____

Exposures:

Please list pets in your home _____

Is there carpet in your bedroom? YES / NO

Please list occupation _____

What are you exposed to at home or work (aerosols, dust, fumes)?_____

List things that have caused you adverse reactions: (which one and what kind of reaction)

Foods: _____

Medicines: _____

Other: (beestings, latex, etc. . .) _____

Have you ever been skin tested? YES / NO When? _____

Have you ever had allergy shots? YES / NO When? _____