

Patient name: \_\_\_\_\_  
Date: \_\_\_\_\_

## Allergy Questionnaire

1. Please circle the symptoms which are most bothersome to you:

Itchy eyes	Itchy nose	Itchy skin
Watery eyes	Runny nose	Facial (sinus
pain	Rashes	Sneezing
Nasal congestion	Ear discomfort	Decreased smell
Headaches	Cough	Hoarse voice

2. What other symptoms bother you? \_\_\_\_\_  
\_\_\_\_\_

3. During which seasons do you have allergy symptoms? \_\_\_\_\_  
\_\_\_\_\_

4. What are the main triggers for your symptoms? \_\_\_\_\_  
\_\_\_\_\_

5. What do you think you are allergic to? \_\_\_\_\_  
\_\_\_\_\_

6. Do your symptoms improve or resolve in different geographic locations? (e.g. vacations, high altitude, desert) \_\_\_\_\_  
\_\_\_\_\_

7. Do your symptoms improve or resolve at different times of the day or locations? (e.g. weekday/weekend; morning/afternoon; outside/inside) \_\_\_\_\_  
\_\_\_\_\_

8. Any other situations where your allergies are worse? \_\_\_\_\_  
\_\_\_\_\_

9. Do certain smells or chemicals cause your symptoms? \_\_\_\_\_  
\_\_\_\_\_

10. Do you have reactions to certain foods?  
What type of reaction? \_\_\_\_\_  
Which foods? \_\_\_\_\_

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11. Do you have any of the following conditions? (if yes, please describe)

- Recurrent or chronic ear infections \_\_\_\_\_
- Recurrent or chronic throat infections \_\_\_\_\_
- Asthma \_\_\_\_\_
- Conjunctivitis \_\_\_\_\_
- Atopic dermatitis \_\_\_\_\_
- Eczema \_\_\_\_\_
- Anaphylactic reactions \_\_\_\_\_

12. Have you had any surgery to your nose, sinuses or ears? \_\_\_\_\_  
\_\_\_\_\_

13. What medications do you take for your allergies? Do they help? \_\_\_\_\_  
\_\_\_\_\_

14. Do you smoke tobacco? (if yes, how much?) *yes / no* \_\_\_\_\_

15. Do you have nasal congestion with alcohol? *yes / no*

16. What do you do for work? \_\_\_\_\_

17. Recent environmental change or a new job? \_\_\_\_\_

18. Hobbies? (e.g. gardening, sports) \_\_\_\_\_

19. Do you have pets at home? (if yes, please list) \_\_\_\_\_  
\_\_\_\_\_

20. Home environment:

Any recent remodeling? *yes / no*

Do you have an air filter? *yes / no*

Carpets in your home? *yes / no*

Basement? *yes / no*

Cockroaches? *yes / no*

Age of your home: \_\_\_ *years*

Well maintained AC/heat? *yes / no*

Moisture problems? *yes / no*

Indoor plants? *yes / no*

21. Family members with any of the following:

Allergies? *yes / no*

Asthma? *yes / no*

Rashes or eczema? *yes / no*