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 with exercise or cold exposure | | |

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? _____

11. Do you have any of the following conditions? (if yes, please describe)
    - ☐ Recurrent or chronic ear infections _____
    - ☐ Recurrent or chronic throat infections _____
    - ☐ Asthma _____

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- ☐ 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*