

Allergy Associates, Inc.
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HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Date: / /

Name <i>(Last, First, M.I.):</i>	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	DOB:
Referring physician: Primary care physician:	Permission to send a report to your physician: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Briefly describe the reason(s) for this visit:	Ethnicity: Race:	

ALLERGY/IMMUNOLOGY HISTORY

Have you ever had the following conditions:

Yes No

Current Problem	Past Problem		(check each item)
			Allergic Rhinitis (hay fever or nasal allergies)
			Allergic conjunctivitis (itchy watery eyes)
			Asthma
			Other breathing problems or lung conditions
			Hives or swelling (urticaria or angioedema)
			Frequent sinus trouble or infections
			Eczema, contact dermatitis, or recurrent rashes
			Food allergy Which foods:
			Nasal polyps
			Recurrent pneumonia
			Immunodeficiency
			Insect sting allergy
			Other allergic condition

Have you ever received allergy shots? <input type="checkbox"/> Yes <input type="checkbox"/> No
For Children < 12 years old: Premature birth <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how many weeks gestation? _____
Normal growth and development: <input type="checkbox"/> Yes <input type="checkbox"/> No If not, please explain:

List any other past or ongoing medical problems.	
1.	5.
2.	6.
3.	7.
4.	8.

Surgeries		Hospitalizations (non-surgical)
Type of Surgery	Year	Reason for hospitalization

CURRENT MEDICATIONS (List your prescribed and over-the-counter medications including inhalers and nasal sprays)

Name of the Medication	Strength	Frequency Taken

ALLERGIES TO MEDICATIONS

Name of the Medication	Describe the reaction	When did the reaction occur?

IMMUNIZATIONS

Immunizations up to date Yes No

SOCIAL HISTORY

Marital Status	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widow
Alcohol	Do you drink alcohol? <input type="checkbox"/> Yes <input type="checkbox"/> No How many drinks per week? _____ Are you concerned about the amount you drink? <input type="checkbox"/> Yes <input type="checkbox"/> No
Tobacco	Do you or did you smoke cigarettes? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Quit date _____ # number of packs per day _____ # number of years of smoking _____

ENVIRONMENTAL HISTORY

What type of work do you do?	Are you in school? <input type="checkbox"/> Yes <input type="checkbox"/> No
Are you exposed to anything at work or school that might aggravate your condition? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Have you missed work or school because of your allergies? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Where do you live? <input type="checkbox"/> urban area <input type="checkbox"/> suburban area <input type="checkbox"/> rural area <input type="checkbox"/> near woods <input type="checkbox"/> near water <input type="checkbox"/> farm	

Your home is a: house apartment condo mobile home other

Your home: has a basement dry wet/damp is on a slab has a crawl space is a split-level

Your bedroom: is carpeted has wood or hard surface floor Your pillow: feather synthetic

Do you have pets? Yes No dog(s) #__ cat(s) #__ other_____

Are your pets allowed indoors? Yes No

Do you experience allergic symptoms when exposed to pets? Yes No

Other relevant allergic exposures:

FAMILY ALLERGY HISTORY

Allergic Condition (✓ where appropriate)	Allergic Rhinitis	Asthma	Food Allergy	Atopic Dermatitis/Eczema	Immunodeficiency/Recurrent Infections
Mother					
Father					
Siblings					
Children					
Other					

OTHER HEALTH PROBLEMS/REVIEW OF SYSTEMS

Check and circle if you have, or have had any symptoms in the following areas to a significant degree and briefly explain if necessary.

<input type="checkbox"/> Skin: hives, eczema, rash	<input type="checkbox"/> Chest/Heart: high blood pressure, chest pain, palpitation	<input type="checkbox"/> Endocrine: diabetes, thyroid disease
<input type="checkbox"/> Eyes: glaucoma, cataract, itching, pain, visual impairment	<input type="checkbox"/> Gastrointestinal: acid reflux, nausea, vomiting, diarrhea	<input type="checkbox"/> Genitourinary: frequent or difficult urination, frequent UTI's, prostate problems
<input type="checkbox"/> Ears: hearing loss, infection, pain, pressure	<input type="checkbox"/> Musculoskeletal: joint pain, back pain, osteoporosis	<input type="checkbox"/> Constitutional: fever, weight change, appetite change, sleep problems
<input type="checkbox"/> Nose: congestion, runny, sneezing, drainage, nose bleeds, polyps	<input type="checkbox"/> Neurologic: dizziness, headache	<input type="checkbox"/> Sleep problems: insomnia, snoring, apnea
<input type="checkbox"/> Throat: pain, itching, hoarseness	<input type="checkbox"/> Psychiatric: anxiety, depression	<input type="checkbox"/> Other problems:
<input type="checkbox"/> Lungs: cough, wheeze, shortness of breath	<input type="checkbox"/> Immunologic: frequent sinusitis, frequent bronchial, infections, immunodeficiency	

Patient (parent) Signature