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 *(Last, First, M.I.)*: Sex: ☐ M ☐ F	**DOB:**
Referring physician: Primary care physician:	Permission to send a report to your physician: ☐ Yes ☐ 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? ☐ Yes ☐ No
For Children < 12 years old: Premature birth ☐ Yes ☐ No If yes, how many weeks gestation? _____
Normal growth and development: ☐ Yes ☐ 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	☐ Single ☐ Married ☐ Divorced ☐ Widow
Alcohol	Do you drink alcohol? ☐ Yes ☐ No How many drinks per week? _____ Are you concerned about the amount you drink? ☐ Yes ☐ No
Tobacco	Do you or did you smoke cigarettes? ☐ Yes ☐ No ☐ 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? ☐ Yes ☐ No
Are you exposed to anything at work or school that might aggravate your condition? ☐ Yes ☐ No
Have you missed work or school because of your allergies? ☐ Yes ☐ No
Where do you live? ☐ urban area ☐ suburban area ☐ rural area ☐ near woods ☐ near water ☐ 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.

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

_____

Patient (parent) Signature