Allergy Questionnaire

1. Major reason for visit: Please describe in your own words any problem(s) your child is having that you believe may be allergy related.

History

2. How long has your child had allergy symptoms?

_____ Months _____ Years

3. Are your child's allergy symptoms getting worse?

❑ Yes ❑ No ❑ Unchanged

4. How frequently do your child's allergy symptoms occur?

❑ Constantly ❑ Occasionally ❑ Rarely

5. When do your child's allergy symptoms occur?

❑ All Months

❑ January ❑ February ❑ March ❑ April

❑ May ❑ June ❑ July ❑ August

❑ September ❑ October ❑ November ❑ December

6. When are your child's symptoms the worst?

❑ Morning ❑ Afternoon ❑ Evening/ Night

7. Where are your child's symptoms the worst?

❑ At home ❑ At school/ work ❑ Other location _____

8. How often do your child's symptoms interfere with daily activities/ sports?

❑ Never ❑ Occasionally ❑ Half of the time ❑ Most of the time ❑ All of the time

9. Does your child miss school because of allergy symptoms?

❑ Never ❑ Occasionally ❑ Frequently

10. Does your child's allergy symptoms disturb his/ her sleep?

❑ Never ❑ Occasionally ❑ Frequently

11. Has your child ever had to go to the emergency room or hospital for an allergic reaction?

❑ Yes ❑ No

12. Has your child ever needed steroids or epinephrine injections for an allergic reaction?

❑ Yes ❑ No

13. Has your child ever had allergy testing?

❑ No ❑ Yes-Blood Test ❑ Yes-Skin Test ❑ Date_____

❑ Results:

14. Which of the following conditions has your child experienced?

❑ Asthma ❑ Bee Sting Allergy ❑ Bronchitis ❑ Chronic Sinus Disease

❑ Drug Allergy (specify) _____ ❑ Eczema ❑ Environmental Allergies ❑ Food Allergy (specify) _____

❑ Hay Fever ❑ Hives ❑ Other_____

15. Which of the following conditions are present in your child's immediate family (parents, siblings, grandparents)?

- ❑ Asthma
- ❑ Drug Allergy (specify) _____
- ❑ Eczema
- ❑ Food Allergy (specify) _____
- ❑ Hay Fever
- ❑ Other_____

Symptom Review

16. Does your child experience any of the following eye symptoms?

- ❑ None
- ❑ Blurred Vision
- ❑ Burning
- ❑ Crusting
- ❑ Dark circles
- ❑ Dryness
- ❑ Itching
- ❑ Redness
- ❑ Swelling
- ❑ Watering
- ❑ Other_____

17. Does your child experience any of the following ear symptoms?

- ❑ None
- ❑ Congested
- ❑ Dizziness
- ❑ Earache
- ❑ Fluid in Middle Ear
- ❑ Frequent Infections
- ❑ Hearing Loss
- ❑ Itching
- ❑ PE (Ear) tubes
- ❑ Popping
- ❑ Other_____

18. Does your child experience any of the following nasal symptoms?

- ❑ None
- ❑ Cloudy Discharge
- ❑ Congestion
- ❑ Frequent nosebleeds
- ❑ Frequent sinus infections
- ❑ Itching
- ❑ Sneezing
- ❑ Sniffles
- ❑ Snoring at night
- ❑ Watery Discharge
- ❑ Other_____

19. Does your child experience any of the following mouth/ throat symptoms?

- ❑ None
- ❑ Difficulty Swallowing
- ❑ Frequent sore throats
- ❑ Hoarseness
- ❑ Itchy Throat
- ❑ Mouth Breathing
- ❑ Swelling of lips
- ❑ Swollen neck glands
- ❑ Other_____

20. Does your child experience any of the following chest symptoms?

- ❑ None
- ❑ Chest pain
- ❑ Chest tightness / congestion
- ❑ Chronic cough
- ❑ Difficulty breathing
- ❑ Shortness of breath
- ❑ Wheezing
- ❑ Wheeze/ cough after exercise
- ❑ Other_____

21. Does your child experience any of the following skin symptoms?

- ❑ None
- ❑ Dry skin
- ❑ Eczema
- ❑ Hives
- ❑ Itchy Skin
- ❑ Poison Ivy/ Oak Allergy
- ❑ Skin sensitivity to chemicals
- ❑ Skin sensitivity to metals
- ❑ Swelling
- ❑ Other_____

Allergy Symptom Triggers

22. Which of the following environmental factors make your child's allergy symptoms worse?

- ❑ Air Conditioning
- ❑ Barns/ hay
- ❑ Clothing/Fabrics
- ❑ Cold Day
- ❑ Cosmetics/perfumes
- ❑ Damp Areas
- ❑ Dust
- ❑ Exercise
- ❑ Fumes/ Sprays
- ❑ High Pollution
- ❑ Hot Day
- ❑ Indoors: _____
- ❑ Insecticides
- ❑ Medications
- ❑ Mowing Lawn/ Grass
- ❑ Outdoors: _____
- ❑ Pets/ Animals
- ❑ Raking Leaves
- ❑ Smoke
- ❑ Tobacco Exposure
- ❑ Tree Exposure
- ❑ Weather Change
- ❑ Wet Weather
- ❑ Other_____

23. Which of the following foods make your child's allergy symptoms worse?

- ❑ None
- ❑ Cheese
- ❑ Chicken
- ❑ Eggs/ Egg products
- ❑ Fish
- ❑ Fruit or Juices
- ❑ Meat
- ❑ Milk/ Dairy Products
- ❑ Mushrooms
- ❑ Nuts/beans/seeds
- ❑ Shellfish
- ❑ Soy
- ❑ Vegetables
- ❑ Wheat Products
- ❑ Other_____

24. Which of the following animals are you exposed to in your home, school or other environment?

- ❑ None
- ❑ Birds
- ❑ Cats
- ❑ Dogs
- ❑ Other_____

Previous Allergy Treatment

25. Which antihistamine medications has your child taken? Please circle the medication if it helped.

- ❑ None
- ❑ Allegra
- ❑ Benadryl
- ❑ Clarinex
- ❑ Claritin
- ❑ Singulair
- ❑ Xyzal
- ❑ Zyrtec
- ❑ Other_____

26. Which nasal spray medications has your child taken? Please circle the medication if it helped.

- ❑ None
- ❑ Astelin
- ❑ Flonase
- ❑ Nasacort
- ❑ Nasonex
- ❑ Rhinocort
- ❑ Veramyst
- ❑ Other_____

27. Which allergy eye drop medications has your child taken? Please circle the medication if it helped.

- ❑ None
- ❑ Pataday
- ❑ Patanol
- ❑ Zaditor
- ❑ Other_____

28. Has your child ever been treated with allergy immunotherapy?

- ❑ No
- ❑ Yes-subcutaneous (injections)
- ❑ Yes-sublingual (under the tongue)
- ❑ Dates: _____

29. If your child has had allergy immunotherapy, what was he/she treated for?

- ❑ Not applicable
- ❑ Animals: _____
- ❑ Dust
- ❑ Grass Pollens
- ❑ Molds
- ❑ Tree Pollens
- ❑ Weed Pollens
- ❑ Other_____

30. Did the allergy immunotherapy help your child?

- ❑ Not applicable
- ❑ Yes
- ❑ No
- ❑ Don't know