ALLERGY HISTORY QUESTIONNAIRE
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MEDICATION INSTRUCTIONS: Benadryl and other store brand antihistamines and decongestants must be stopped at least three days prior to skin testing. Antihistamines that need to be stopped for 7 days prior to testing are XYZAL, ZYRTEC, CLARITIN, CLARINEX, and ALLEGRA. If you have concerns about stopping any of your medications, please feel free to contact our office at (406)728-6472 and we will be happy to address any questions or concerns.

Please complete this questionnaire and bring it with you to your appointment. If the question does not apply to you or the patient please fill in "N/A"

Patient Name:_____ Age:_____ Birth date:_____
Parents Name (if patient is a minor):_____
Address:_____Phone:_____
Referring Physician:_____

A) When was the last time you took an antihistamine? _____ Name of antihistamine: _____

B) List of current medications (prescription and over the counter medications)

Name of Drug	Dosage (10mg, 2 puffs, etc)	How often taken (daily, as needed, etc)

C) List any medications including antibiotics that you are allergic to or are intolerant to _____
_____

D) **Reason for Evaluation**

1. Please summarize briefly What are your MAIN concerns (this is the most important question):

2. What symptoms do you feel may be due to an allergy?_____
_____

3. Age symptoms began?_____

E) **If patient wheezes, complete the following:**

1. With what symptoms does the wheezing problem begin?_____
2. List the symptoms which then appear in order of _____
occurrence:_____
3. At what age did the wheezing begin? _____
4. Has it improved? _____ Worsened? _____To what do you attribute this?_____
5. When do the symptoms seem worse? All Year _____ Spring_____ Summer_____ Fall_____ Winter_____
6. Wheezing episodes occur _____ days per week during wheezing periods.
7. When does the wheezing usually occur? Morning _____ Afternoon _____ Evening _____
8. How long does the wheezing period last? _____

9. How often are the severe wheezing episodes? _____ How long do the severe episodes last? _____

10. Check the items which apply: Occasional wheezing _____ frequent wheezing _____ Constant wheezing _____ Cough leading to wheezing _____ Fever with wheezing _____ wheezing with exertion _____ Chest pain with wheezing _____
11. What medications have been used to control the wheezing and how effective is each? _____
12. Did any medications cause any problems? _____
13. Has any of the following been given to control the wheezing? Adrenalin _____ Cortisone or cortisone-like drugs? _____
14. Has the severity of an attack requires hospitalizations? No ___ Yes____ When? _____ Where? _____

F) Nose

1. Check the items which apply to nasal symptoms: Itching of nose or mouth _____ Nasal congestion _____ Clear nasal discharge_____ Colored nasal discharge _____ Fever with symptoms _____ Mouth breathing _____ Constant clearing of the throat _____ Sneezing _____ Bad Breath _____ Post nasal drip _____ Loss of smell _____ Nasal Polyps _____ Snoring _____ Sinus infections _____
2. At what age did these symptoms start? _____
3. When do the symptoms seem worse? All year _____ Spring _____ Summer _____ Fall ____ Winter _____
4. What medications have been used to control these symptoms and how effective is each? _____

G) Infections

1. How many "colds" occur per year? _____ With wheezing? _____
2. How often does tonsillitis occur each year? _____ With wheezing? _____ Has patient had tonsillectomy? (yr) _____ Adenoidectomy? (yr)_____
3. Have there been episodes of Croup?____ Bronchiolitis ?_____ Bronchitis?____ Pneumonia ?____Chest infections (date of last) _____
4. What antibiotics have been used to treat infections? _____

H) Headaches

1. Seldom_____ Occasionally _____Frequent_____
2. Contributing factors? _____

I) Eye Complaints

1. Check symptoms that apply to you or the patient: Frequent itching _____ Frequent redness and or tearing _____ Swelling of eye lids_____ Discharge from eyes _____ Sensitivity to light _____ Blurring of vision _____ Burning sensation _____
2. How often have these symptoms been a problem within the past year? _____

J) Ear Complaints

1. Check symptoms that apply to patient: Frequent earaches _____ Loss of hearing _____ Ear infections_____ Dizziness_____ Discharge from ears_____

K) Skin

1. Check symptoms that apply to patient: Eczema _____ When? _____ Due to what? _____ Recurrent Rash _____ Hives ____ When? _____ Due to what? _____Cold water hives or swelling ____ Frequent skin infections (impetigo) _____ Dry or itchy skin? _____

L) Foods

1. Check any of the following that foods cause: Itching of lips or mouth _____ Itching of the skin _____ Hives _____ Eczema _____ Rash _____ Headaches _____ Runny Nose _____ Nausea/vomiting _____ Wheezing _____ Stomach Cramps _____ Diarrhea _____ Other? _____
2. Have any foods been eliminated from the diet? _____
3. Did this change the severity of symptoms? _____
4. Is there a large intake of any particular food or beverage? _____

M) Precipitating factors of coughing, wheezing, nasal congestion, or sneezing

1. Check the items or situations that will cause any of the above symptoms to start or become worse:

___Outdoors	___Child discipline	___Road dust	___Same everywhere
___Wet weather	___Home/indoors	___Cosmetics/perfume	___January
___Dry clear weather	___Cleaning house	___Hairspray	___February
___Change from clear to rainy	___Contact with old furniture	___Hair shampoos/rinses	___March
___Change from rainy to clear	___Attic/basement	___Hand/facial lotions	___April
___Sudden change in temp	___Air conditioning	___Body/facial powders	___May
___Onset of cold weather	___Contact with dogs or cats	___Toothpaste/tooth powder	___June
___Change in humidity	___Contact with other animals	___Aspirin	___July
___Sudden chilling	___Contact with feathers/wool	___Laundry soap powder	___August
___Cold feet	___Newly mowed grass	___Flour dust	___September
___Exertion	___While on vacation	___Insect dust/sprays	___October
___Fatigue	___Seashore	___Fertilizers	___November
___Laughing	___Boat/airplane ride	___Smoke or odors	___December
___Coughing	___School/work/recreation	___Old leaves	
___Emotional upset	___Being in the woods/mountains	___Flowers	
	___Car ride	___Other	

2. Does anything from the list above (or anything else) cause improvement or worsening of symptoms?

_____

N) Problems the symptoms create for the patient:

1. Is there limitation of work? _____ Exercise? _____ Play? _____
2. Due to what symptoms? _____
3. How many work/school days were missed during the past year due to this problem? _____
4. Have there been any long periods of freedom from symptoms? _____
5. To what do you attribute this? _____
6. Is there any place where the patient is symptoms free? _____

O) Residence when onset of symptoms occurred

1. State _____ Date of resident _____
2. Symptoms were: Seasonal _____ Year round _____ How severe? _____

P) Previous allergy evaluations

1. Place where evaluated before? _____ Date _____
2. What were the results? _____
3. Have allergy injections been received in the past? No____ Yes ____ Give the start and stop dates of desensitization _____ to _____
4. What was the composition of the allergy infections? _____
5. Was there any improvement after having the allergy injections of a period of time? ____No ____ Yes
6. Other studies done: _____

Q) Allergic Reactions

1. What type of reaction when stung by a bee or wasp? _____
2. What medication did you take? _____
3. Did you have to go the hospital? _____ Where? _____

R) Personal Medical History

1. List any other medical conditions:

_____
_____
_____
_____
_____
_____

2. Does the patient have a heart condition or heart arrhythmia? (please specify) _____
3. Check immunizations that have been completed: DPT series_____ Polio series _____ MMR _____ Hepatitis B series____ Varicella _____ Hib series_____ Flu shot ____ Date of last Flu Shot?_____ Pneumovax_____ Date of last pneumovax_____

S) **Family History**

	Father	Mother	Brothers	Sisters
1. Age				
2. Hay Fever				
3. Asthma				
4. Eczema				
5. Hives				
6. Sinus Trouble				
7. Heart Condition				

8. Does any member of the family have a chronic illness? (specify)_____
9. List any other medical problems you feel may be of importance._____
10. Is there any family member deceased?_____ Cause?_____
11. Does any illness seem to occur on either side of the family? _____

T) **Environmental History (where patient lives and what he/she is exposed to)**

1. Residence: Check which applies to your home Urban___ Rural___ Farm___ Older house____Newer house___ Apartment___
2. Does the home have an attic? (describe) _____ Basement? (describe)_____
3. Is the home near a factory? (describe)_____ Farm? (describe) _____
   Fields or wooded areas? (describe) _____
4. Type of trees in your yard and neighborhood?_____
5. Type of grass, flowers, or shrubs in the yard? _____
6. Check which applies to the residence's heating system: Central ____ Hot water _____ Electric _____ Gas _____ Wood _____
7. Check which applies to the residence's cooling system: None ____ Central AC ____ Window unit AC ___ Swamp cooler _____
8. What kind of pets are in/out of the home? _____
9. What kind of house plants are in the home? _____
10. Does anyone smoke in the home or car? Yes_____ No_____ Specify_____
11. Is there any place in the home where the patient's symptoms are worse?_____
12. Check the following that pertain to the patient's bedroom: Heat or cooling vents____ Overstuffed furniture ____
    Stuffed toys ____ Cosmetics/ powders/ hairspray ____ scented products (e.g. candles, potpourri) ____ out of season clothes in Closet ____ airtight covers for pillows or mattress _____
13. Check and describe type for any of the following items that are in the patient's bedroom:
    Carpet/ rug pad: _____
    Throw rugs: _____
    Curtains: _____
    Mattress: _____
    Pillows: _____
14. Number of beds in room: _____ Number of persons sleeping in room _____
15. Is there mold growing anywhere in the house (describe)?_____
16. Is there anything in your house or yard/around residence that has not been mentioned that you think is significant in contributing to the patient's symptoms?_____
17. What changes have you implemented to the patient's environment to improve his/her symptoms?_____
    _____

U) **Other Comments:**