ALLERGY/ASTHMA QUESTIONNAIRE

TO BE COMPLETED BY PATIENT **PLEASE PRINT**

NAME_____ **DATE**_____

Briefly describe your symptoms:_____

_____

_____

How long have you had these symptoms_____ Occupation_____

Time missed from work/school in the past year?_____ Does your job cause/worsen your condition? Y N

For the following questions, please answer using the signs: **Y=Yes N=No ?=Not Sure 0=Not Applicable**

Do you have allergies or have you had an allergic reaction_____ To What_____

Have you been tested for allergies_____ What Year_____ Where_____

How were you tested_____ By Whom_____

Have you taken allergy shots_____ For What_____ How Long_____

Have you had Pulmonary or Breathing testing_____ What Year_____ Where_____

By Whom_____ How were you tested_____ Results_____

Do you have any other active diseases_____ Please list_____

Do **you** have a history of Asthma_____ Hives_____ Emphysema_____ Pneumonia_____ Eczema_____

Migraines_____ Hay Fever_____ Bronchitis_____ Pleurisy_____ Lung Cancer_____ Colitis_____ Tuberculosis_____

Do any of your **relatives** have a history of the above conditions_____. Please list who, and which condition(s).

_____

_____

Smoking History Cigarettes_____ Pipe_____ Cigar_____ Year started_____ Number per day_____

Have you quit smoking_____ Do other members of your household smoke_____ Who_____

Environment How old is your current residence_____ Number of years at current residence_____

Is your current residence a House_____ Apartment_____ Mobile Home_____ Farm_____ Other_____

Do you have pets a home _____ Which ones_____

If on a farm, what types of animals are you exposed to_____

Pillows Polyester_____ Feather/Down_____ **Blanket** Wool_____ **Mattress** Feather_____ Hair_____

Floor Carpeted_____ **Home Heating** Oil/Gas_____ Electric_____ Coal_____ Wood_____ Other_____

Heat Delivery Forced Air_____ Radiators_____ **Air Conditioning** Central_____ Window Units_____

Do you use a humidifier_____ Do you have stuffed animals_____ Do you have bookcases_____ Plants_____

Foods Are symptoms caused are made worse by foods_____ Which ones_____

***Physical* Symptoms** **Eyes** Redness_____ Itching_____ **Ears** Popping_____ Fluid_____ Infection/Pain_____

Throat Frequent Infections_____ Dry mouth in AM_____ Hoarseness_____ **Sinuses** Blockage_____ Infections_____

Nose Frequent stuffiness_____ Discharge_____ Post nasal drip_____ **Cough** Waking up in AM_____

Throughout the day_____ Awakened at night_____ Dry/Tight_____ Produce sputum_____ Color_____

Blood_____ Every morning/night_____ 3 times week_____ Once a week_____ Once a month_____

Shortness of Breath _____ Age of onset_____ During strenuous exercise_____ Describe_____

During moderate exercise_____ Describe_____

Wheezing/Chest Tightness _____ Awakened at night_____ Relieved by_____

Every morning_____ 3 or more times per week_____ Once a week_____ Once a month_____

For the following questions, please answer using the signs: **C=Coughing S=Shortness of Breath W=Wheezing**

Which of the factors listed below cause or worsen your coughing, shortness of breath or wheezing.

Exercise_____ Smoke_____ Cold_____ Alcohol_____ Foods_____ Dust_____ Irritants_____ Dampness_____

Stress_____ Cosmetics_____ Pets_____ Weather changes_____ Colds/Flu _____ Drugs_____ Emotion_____

Any changes when traveling to Beach_____ Desert_____ Mountains_____ Other_____

Please list your hobbies_____

Have you traveled outside the country in the last year_____ Where_____

Do you check your breathing with a peak flow meter_____ How often_____ Do you maintain an asthma diary_____

Reviewed by Physician_____ Date_____