Asthma, Allergy, and Immunology Review

Date _____

Name _____ Age _____

Occupation _____

Give a brief description of your workplace or school:

Referred by _____

Please answer all the questions on all seven pages to the best of your ability. Base your answers on your own observations and not on what others have told you or what you may have presumed based on previous allergy tests. Complete the questionnaire before you see the physician as the information will organize your thoughts and facilitate understanding of your case.

1. Describe in your own words your symptoms, which might reflect your allergic/exaggerated reaction.

---

2. Check the boxes and complete the blanks as they apply to your symptoms.

Do you wear contacts? _____	Present problem	Past Problem
A. Eye symptoms		
Itching	☐	☐
Watering	☐	☐
Redness	☐	☐
Swelling	☐	☐
Burning	☐	☐
Dryness	☐	☐
Foreign body sensation	☐	☐

B. Symptoms in the upper respiratory tract; nose, sinuses, throat, eustachial tubes, voice box.

	Present problem	Past problem
Itching	☐	☐
Sneezing	☐	☐
Congestion	☐	☐
Headache	☐	☐
Obstruction	☐	☐
Drainage	☐	☐
Soreness	☐	☐
Dryness	☐	☐
Hoarseness	☐	☐
Hearing loss	☐	☐
Polyps	☐	☐
Impaired smell/ taste	☐	☐
Snoring	☐	☐

C. Symptoms of the lower respiratory tract; windpipe, bronchi, lungs

	Present problem	Past problem
Itching	☐	☐
Coughing	☐	☐
Sputum production	☐	☐
Congestion/ tightness	☐	☐
Wheezing	☐	☐
Shortness of breath	☐	☐
Pain	☐	☐

D. Symptoms in the stomach and digestive system which you suspect might be allergic

	Present problem	Past problem
Pain or difficulty swallowing	☐	☐
Nausea or vomiting	☐	☐
Heartburn/ Indigestion	☐	☐
Abdominal cramping	☐	☐
Constipation/ Diarrhea	☐	☐

E. Skin reaction to:

	Present problem	Past problem
Hives	☐	☐
Giant Swelling	☐	☐
Eczema	☐	☐
Poison ivy/ oak	☐	☐
Metal	☐	☐
Yellow jacket sting	☐	☐
Other stinging insects	☐	☐

F. Reaction to drugs	Present problem	Past problem
Immunizations	☐	☐
Penicillin Date last taken _____	☐	☐
Aspirin Date last taken _____	☐	☐
Sulfa	☐	☐
Nose drops/ Spray	☐	☐
Sedatives	☐	☐
Pain relievers	☐	☐
Hormones	☐	☐
Antihistamines	☐	☐
Cortisone	☐	☐
X-ray dye	☐	☐
Others	☐	☐

G. Seasonal aspect of symptoms	Present problem	Past problem
Spring (March, April, May)	☐	☐
Summer (June, July, August)	☐	☐
Autumn (Semptember, October, November)	☐	☐
Winter (December, January, February)	☐	☐

H. How many ordinary colds and flu illnesses have you had in the last year? _____

How many cold and flu on average in the last five years? _____

What proportion (0,10,25,50,75,90,100%) of these are complicated by:

Ear infection _____%

Earache _____%

Decreased hearing _____%

Sinusitis _____%

Pressure or discolored drainage _____%

Bronchitis or cough with discolored sputum _____%

Asthma, chest tightness, wheezing _____%

What proportion (0,25,50,75,90,100%) required antibiotics for resolutions?_____ %

I. Which antibiotic(s) work best for you? _____

_____

_____

J. Have you tried any of the medications listed below?

	Received	% Relief	Side Effects
1. Zyrtec	☐		
2. -Claritin	☐		
3. Clarinex	☐		
4. Allergra	☐		
5. Allergra D	☐		
6. Xyzal	☐		
7. Flonase	☐		
8. Rhinocort	☐		
9. Nasacort	☐		
10. Nasonex	☐		
11. Flovent	☐		
12. Astelin	☐		
13. Advair	☐		
14. Serevent	☐		
15. Singular	☐		
16. Accolate	☐		
17. Theophylline	☐		
18. Azmacort	☐		
19. Pulmicort	☐		
20. Xopenex	☐		
21. Aerobid	☐		
22. Vanceril	☐		
23. Asmanex	☐		
24. Proventil	☐		
25. Atrovent	☐		
26. Over the counter antihistimines	☐		

3. Check or complete the correct answers to describe your residence and workplace:

Type of dwelling: House ☐ Apartment ☐ Condominium ☐ Dormitory ☐ Mobile/ Motorhome ☐

Location of dwelling: Seashore ☐ City ☐ Mountains ☐ Country ☐ Desert ☐

Age of dwelling: _____ Years of occupancy _____

Obvious mildew/ mold _____ Roaches _____

Type of heating: _____

Type of air conditioning _____

Type of filter _____ Humidifier _____

Bedroom heating _____

Bedroom air conditioning _____

Type of filter _____Humidifier _____

Bedroom floor covering: Carpet ☐ Wood ☐ Cement ☐ Linoleum/ tile ☐

Bed mattress: Conventional ☐ Age in years _____

Water bed ☐ Allergen encasement ☐

Pillows: Feathers/Down ☐ Foam rubber ☐ Dacron/ synthetic ☐ Age in years _____

Indoor animals: Cat ☐ Dog ☐ Bird ☐ other_____

Outdoor animals: Cat ☐ Dog ☐ Horse ☐ other_____

Daily contact with animals; Cat ☐ Dog ☐ Bird ☐ Other_____

4. Check appropriate box for symptoms aggravated or precipitated by exposure or during….

	Eyes	Nose Sinus Ears	Chest	Digestive	Hive Swelling	Eczema
Sleep	☐	☐	☐	☐	☐	☐
On awakening	☐	☐	☐	☐	☐	☐
At work	☐	☐	☐	☐	☐	☐
At play	☐	☐	☐	☐	☐	☐
Vacations	☐	☐	☐	☐	☐	☐
Exercise	☐	☐	☐	☐	☐	☐
Heat	☐	☐	☐	☐	☐	☐
Cold	☐	☐	☐	☐	☐	☐
Dampness	☐	☐	☐	☐	☐	☐
Air conditioning	☐	☐	☐	☐	☐	☐
Weather changes	☐	☐	☐	☐	☐	☐
Emotional upset	☐	☐	☐	☐	☐	☐
Laughter, etc.	☐	☐	☐	☐	☐	☐
Sunlight	☐	☐	☐	☐	☐	☐
Irritant fumes	☐	☐	☐	☐	☐	☐
Aerosols/ sprays	☐	☐	☐	☐	☐	☐
Smog	☐	☐	☐	☐	☐	☐

Cosmetic/ perfumes	☐	☐	☐	☐	☐	☐
Tobacco smoke	☐	☐	☐	☐	☐	☐
Newsprint	☐	☐	☐	☐	☐	☐
House dust	☐	☐	☐	☐	☐	☐
Road dust	☐	☐	☐	☐	☐	☐
Cats	☐	☐	☐	☐	☐	☐
Dogs	☐	☐	☐	☐	☐	☐
Birds/feathers	☐	☐	☐	☐	☐	☐
Other animals	☐	☐	☐	☐	☐	☐
Eggs	☐	☐	☐	☐	☐	☐
Milk/ milk products	☐	☐	☐	☐	☐	☐
Wheat/ wheat products	☐	☐	☐	☐	☐	☐
Corn/ corn products	☐	☐	☐	☐	☐	☐
Strawberries/ other berries	☐	☐	☐	☐	☐	☐
Peanut/ other nuts	☐	☐	☐	☐	☐	☐
Shellfish	☐	☐	☐	☐	☐	☐
Fish	☐	☐	☐	☐	☐	☐
Dried fruit	☐	☐	☐	☐	☐	☐
Restaurant meals	☐	☐	☐	☐	☐	☐
Beer/ wine	☐	☐	☐	☐	☐	☐
Chocolate	☐	☐	☐	☐	☐	☐
Other foods	☐	☐	☐	☐	☐	☐
Menstrual cycle	☐	☐	☐	☐	☐	☐
Other	☐	☐	☐	☐	☐	☐

5. Complete the blanks or check the characteristics that best describe yourself.

Number of days of work/ school missed in the past year? _____

Number of practitioners seen in the past year? _____

Number of emergency/ urgent care visits in the past year? _____

Number of days in the hospital in the past year? _____

Aerobic type exercise? _____Hours per week _____

Packs of cigarettes smoked per day _____ other tobacco per week_____

Bottles of beer per week _____Alcoholic drinks per week _____

Smokers in residence _____ Relationship _____

6. Family history of allergy

	Eyes	Nose Sinus Ears	Chest	Digestive	Hive Swelling	Eczema
Mother	☐	☐	☐	☐	☐	☐
Father	☐	☐	☐	☐	☐	☐

Siblings	☐	☐	☐	☐	☐	☐
Children	☐	☐	☐	☐	☐	☐

Year of last immunization for: Influenza _____ Pneumonia _____

Tetanus _____ Measles _____

Please list your current medications, dosages, route, and frequency taken_____

_____

_____

_____

Please list surgeries that you have had and the month and year of surgery _____

_____

_____

_____

Patient/ Parent Signature _____

Date _____