Mike S. Shin, MD

Allergy History/Patient Questionnaire

Patients Name____________________________________ Sex:_________ Date:___________________________ Age_________

Please answer the following questions as accurately as possible. Your answers will help us determine the cause of your allergy symptoms.

	Yes	No	?
Trouble with your skin?			
Eczema			
Hives			

	Yes	No	?
Trouble with your ears?			
Popping			
Itching			
Hearing Loss			
Fluid in Ears			
Infection/Pain			

	Yes	No	?
Trouble with throat?			
Frequently sore/drainage			
Itching throat/mouth			

	Yes	No	?
Trouble with eyes?			
Redness			
Itching			
Tearing			
Puffiness			

	Yes	No	?
Trouble with nose?			
Clear/colorless discharge			
Thick/colored discharge			
Nasal itching/rubbing			
Constant stuffiness			
Sniffles			
Sneezing			
Mouth breathing or snoring			

	Yes	No	?
Are your symptoms mild?			
Moderate			
Severe			
Present most of the time			
Present part of the time			
Present rarely			
Interfering with your life			
Preventing may normal activities? Please specify below			

	Yes	No	?
Trouble with chest?			
Wheezing with colds			
Wheezing when exposed to dust pollen, animal, etc			
Wheeze/cough after exercise			
Cough			
Deep or productive			
Loose			
Constant			
Dry/tight			
Daytime			
Nighttime			

Which of the following cause or aggravate your symptoms?	Yes	No	?
Indoors			
Outdoors			
At home			
At work			
Morning			
Afternoon			
At night			
Weather change			
Dry weather			
Windy day			
Hot day			
Cold day			
Air conditioning			
In barns			
Damp areas			
Hay, circus			
Mowing lawn			
Dusty environment			
High air pollution			
Animas			
Cooking odors			
Smoke			
Soap powder			
Insecticides			
Paint fumes			
Perfumes			
Cosmetic			
Wave sets			
Newspapers			
Wool			
Road dust			
Milk or milk products			
Eggs			
Wheat products			
Nuts, beans or seeds			
Chocolate			
Fish			
Meat			
Fruit			
Vegetables			
Alcoholic beverages			
Cheese, mushrooms			
Beer			
Wine			
Aspirin			

Chemicals (list)

Drugs (list)

During what months do you usually have symptoms?	Yes	No	?
All months			
January			
February			
March			
April			
May			
June			
July			
August			
September			
October			
November			
December			

Describe what symptoms bother you

When did your condition begin?

	Yes	No	?
Do you use medication regularly for nasal symptoms			

What medication?

	Yes	No	?
Does it help?			

	Yes	No	?
Do any of your blood relatives have allergies?			
Have you ever had skin test for allergies?			
Do you have allergies?			

What are you allergic to?

Is there anything else about your problem which you think might be important or unusual?

	Yes	No	?
Do you have a history of:			
Migraine headaches			
Skin disease			
Heart disease			
Frequent headaches			
Sinus disease			
Stomach disease			
Asthma			
Nasal polyps			
Emphysema			
Broken nose			
Overactive thyroid			
Bronchitis			
Nasal surgery			
Underactive thyroid			
Hay fever			
Deviated septum			
Hormonal difficulty			
Hives			
Food allergy			

Drug allergy (describe):

Other conditions (describe):

Do you take any medication for any of the previous conidtions? List:			
Do you think your occupation has anything to do with your symptoms? Describe:			

Describe your occupation:

Any materials used in your occupation that may be something to do with your condition? Describe:			

At work are your symptoms			
Better			
Worse			
The same			

Do you use a humidifier?			
Cold mist or steam?			
Do you have air conditioning?			
At work?			
At home?			
Central?			
Window unit in bedroom?			

	Yes	No	?
Do you spend a good deal of time in activities? List:			

Do you take any medications daily or frequently?			
Aspirin			
Cortisone			
Laxatives			
Sedatives			
Birth control pills			
Vitamins			
Ointments			
Nose drops/sprays			
Hormones			
Others?			

Specify:

Smokers in your home?			
Do you smoke?			

Cigarettes #__________________ per day

Cigars #______________________per day

Pipe #_______________________ per day

Years smoked?________________________

Stopped smoking in year ___________________

Do you have animals in your home? List:			
Have you ever had animals in your home? List:			

Do you live in:			
House?			
Apartment?			
In the city?			
In the subarbs?			

Is you dwelling:			
New?			
3-10 years old?			
11-25 yearls old?			
25+ years old?			

	Yes	No	?
Is your bedroom on:			
Lower floor			
Main floor			
Upper floor			
Wall to wall carpet?			

If so, age of carpet? _____________________

Do you sleep with a pillow? Circle one

Dacron Foam Rubber Feather

Is your mattress? Circle one

Cotton Feather Foam rubber Horse hair

Other:

Is your heating system? Circle one

Oil Gas Electric Wood stove

Other:

Is delivered by? Circle one

Blower Radiators Electric panels

Other:

Filter? Circle one

Fiberglass HEPA Permanent electrostatic

How often cleaned or changed?__________________

Ducts cleaned?

When?

How often?

Do you have a basement?			
Do you have a crawl space?			
Vapor barrier under house?			

Exhaust fan? Circle one

Basement Laundry Kitchen Bath

Is vacuum? Circle one

Canister Upright Central

Vacuum bag type? Circle one

Permanent Disposable HEPA water

Family room:			
Wall to wall carpet?			

If so, age of carpet?_______________

Hard surface in family room?			