

ALLERGY QUESTIONNAIRE

PLEASE COMPLETE THIS FORM AND
BRING IT WITH YOU WHEN YOU BRING
YOUR CHILD FOR HIS/HER APPOINTMENT.

THIS IS NOT A DOCTOR'S REPORT

NAME:

DATE OF BIRTH:

DATE:

1. IN YOUR OWN WORDS, PLEASE GIVE HISTORY OF YOUR CHILD'S MEDICAL PROBLEM: (AGE IT STARTED AND HOW IT PROGRESSED AND CHANGED).

2. WHAT MAKES SYMPTOMS WORSE: (CIRCLE)

FOOD	DRUGS	DOG	CAT	OTHER ANIMALS
DRAFTS	NERVOUSNESS	COSMETICS	PERFUMES	AIR CONDITIONING
HUMIDITY	LYING DOWN/SLEEP	EXERCISE	INFECTIONS	CUTTING THE GRASS
FATIGUE	MENSTRUAL PERIOD	ODORS	OUTDOORS	INDOORS
WINTER	SPRING	SUMMER	FALL	OTHER _____

3. WHAT MAKES SYMPTOMS BETTER:

4. LIST MEDICATIONS USED: (OBTAIN INFORMATION FROM PHARMACIST OR DOCTOR IF NECESSARY)

5. WERE SKIN TESTS DONE IN THE PAST? YES NO DATE: _____

6. ALLERGY BLOOD TESTS (i.e. "RASTs")? YES NO DATE: _____

FAMILY HISTORY OF ALLERGY (please check appropriate column by each relative who has the allergy)						
	ASTHMA	NASAL HAYFEVER	ECZEMA	FOOD ALLERGY	CYSTIC FIBROSIS	IMMUNE-DEFICIENCY
MOTHER						
FATHER						
SISTER						
BROTHER						
MATERNAL AUNT						
MATERNAL UNCLE						
PATERNAL AUNT						
PATERNAL UNCLE						
MATERNAL GRANDMOTHER						
MATERNAL GRANDFATHER						
PATERNAL GRANDMOTHER						
PATERNAL GRANDFATHER						
Age of Home?	How long at present home?		Remodeling? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, what type?	Type of Home: (please check one) <input type="checkbox"/> Single Family <input type="checkbox"/> Condominium/Townhouse <input type="checkbox"/> Apartment/Duplex		
Outdoor Surroundings? (please circle) Factories / Woods / Water		Heating: (please circle) Forced Air / Hot Water / Radiator Baseboard / Space Heater		Air Conditioning: (please circle) None / Window / Central		
Air filter or furnace changed? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, how often?	Humidifier? <input type="checkbox"/> YES <input type="checkbox"/> NO Freestanding? <input type="checkbox"/> YES <input type="checkbox"/> NO Clean w/bleach? <input type="checkbox"/> YES <input type="checkbox"/> NO		Basement: (please circle) Damp / Dry / Slab / Flood Damage / Crawl Space		Fireplace? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, gas or wood? Is Fireplace used? <input type="checkbox"/> YES <input type="checkbox"/> NO	
Smokers at home? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, in patient's room? <input type="checkbox"/> YES <input type="checkbox"/> NO		Animals? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, what type(s)?		Carpeting? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, in patient's room? <input type="checkbox"/> YES <input type="checkbox"/> NO		
Do you have problems with ... Cockroaches ? <input type="checkbox"/> YES <input type="checkbox"/> NO Mice? <input type="checkbox"/> YES <input type="checkbox"/> NO						
<hr/> <hr/> <p>PRIMARY CARE PHYSICIAN: NAME: _____ ADDRESS: _____ TELEPHONE: _____</p> <p>WHO WERE YOU REFERRED BY? <input type="checkbox"/> PRIMARY CARE PHYSICIAN <input type="checkbox"/> SELF <input type="checkbox"/> OTHER (NAME) _____</p> <p>DATES AND LOCATIONS OF PREVIOUS HOSPITALIZATIONS: _____</p> <hr/>						