KAISER PERMANENTE®

ALLERGY AND IMMUNOLOGY QUESTIONNAIRE

PATIENT NAME	DATE
OCCUPATION	AGE

IMPRINT AREA

Please check your symptoms and complaints:

CHEST	NOSE	EARS	EYES	THROAT	SKIN	OTHER
☐ Asthma	☐ Hay fever	☐ Itching	☐ Itching	☐ Itching	☐ Itching	☐ Headache
☐ Cough	☐ Congestion	☐ Blockage	☐ Tearing	☐ Hoarseness	☐ Hives	☐ _____
☐ Wheeze	☐ Sneezing	☐ Frequent infection	☐ Swelling	☐ Frequent infection	☐ Eczema	☐ _____
☐ Tightness	☐ Running		☐ Redness	☐ Post nasal drip		☐ _____
☐ Shortness of breath	☐ Itching			☐ Soreness		☐ _____
☐ Frequent infections	☐ Polyps			☐ Dryness		
☐ Congestion	☐ Loss of smell			☐ Bad Breath		
	☐ Discharge					

Which symptoms cause you the most concern? _____

_____

When did your symptoms begin? _____Month _____ Year _____

In what city or area were you when you first experienced your symptoms? _____

Are your symptoms worse any season of the year? If so, which months; _____

_____

Worst month(s)? _____Best month(s)?_____

Frequency of attacks? ☐ Daily ☐ Weekly ☐ Monthly Worse: ☐ Day ☐ Evening ☐ Night

FAMILY HISTORY:

	FATHER	MOTHER	BROTHER	SISTER	SON	DAUGHTER
Nasal Allergies (Hay Fever)						
Asthma						
Sinusitis						
Hives						

List all known allergies to drugs and food: (if none, please write none).

Name of Drug **Describe Reaction**

A. _____
B. _____
C. _____
D. _____

Medicines: Include birth control pills, vitamins, and aspirin products if used often. Give the strength of prescription drugs you presently take.

A. _____ **D.** _____
B. _____ **E.** _____
C. _____ **F.** _____

Hospitalizations and operations:

YEAR **Reason for Hospitalization**

A. _____
B. _____
C. _____
D. _____
E. _____

Have you had previous skin testing? ☐No ☐Yes, when? _____

If your symptoms include hay fever, nasal allergy, "sinus", wheezing, cough, shortness of breath, or asthma, please read the following list. Carefully and indicate by placing an "X" in the appropriate boxes to the left of those items that cause or aggravate, relieve or have no apparent effect upon your allergy symptoms. EVEN A SMALL CHANGE IS SIGNIFICANT. If you have never encountered the situation or item, please leave all three boxes blank. If your symptoms DO NOT include any of those mentioned above, please leave this section blank.

Causes or Aggravates	Relieves	No Effect	Items
			Lawn mowing, grass contact
			Weed contact, *specify*:
			Blossoming trees, *specify*:
			High winds, riding in auto with open windows
			Strong odors, sprays, perfumes, paints
			Musty, moldy, or mildewed places or articles
			Going indoors
			Going outdoors
			Sweeping, dusting, vacuuming in the house, dusty books, etc.
			Any animals, *specify*:
			Aspirin or aspirin-containing medications
			Emotional upset
			Exertion or strenuous exercise, *specify:*
			Respiratory infections, virus infection, "flu"
			Air conditioning, swamp coolers, etc., please circle
			Antihistamines or nasal decongestants (Contac, Dristan, Allerest, Dimetapp, Ornade, Drixoral nasal spray, etc.), *specify*:
			Medications for wheezing (Tedral, Marax Bronkaid, theophylline, aminophylline, terbutaline, Alupent, etc.), circle and *specify* if other:
			Corticosteroids (cortisone type drugs), *specify*:
			Other drugs which aggravate or relieve symptoms, *specify*:
			Very cold weather, changes in temperature or barometric pressure, *please circle*
			Any trips out of this area, *specify* place and time of the year:
			Alcoholic beverages, *specify*:
			Menstrual periods and/or pregnancy, *please circle*
			Tobacco smoke and other smokes, smog, fumes and haze, *please circle*
			Anything else you have noticed that changes your symptoms, *specify*:

	Yes	No
1. Smoking in house	☐	☐
Patient smokes	☐	☐

_____packs _____years

2. Alcohol _____daily _____social

3. Nonprescription drugs ☐ ☐

	Yes	No
4. Are you sensitive to latex	☐	☐
i.e, rubber gloves, condoms?		

ENVIRONMENT: Please check:

House = ☐own ☐rent _____years

Apartment = ☐own ☐rent _____years

Animals = ☐indoor ☐outdoor ☐bedroom

Pillow = ☐leather ☐foam ☐synthetic

Carpet = ☐wall to wall ☐wood floor

Heating = ☐wall heater ☐central heat ☐gravity

Mattress = ☐standard ☐waterbed

Box Spring = ☐standard ☐none

Mold = ☐indoor plants ☐bathroom ☐kitchen ☐basement ☐walls