PATIENT ALLERGY QUESTIONNAIRE

Patient Name:___________________________________ Date: _____________

Date of Birth:____________________________ HOSP NO : _____________

Please check the boxes that apply:

1. Does your nose feel……

	Never	Sometimes	Seasonally	Constantly
Stuffy				
Runny				
Itchy				
Post-Nasal Drip				

2. Do your Ears feel…….

	Never	Sometimes	Seasonally	Constantly
Stopped Up				
Itchy				
Sore				
It Discharges				

3. Do you have Nasal Blockage…..

	Never	Sometimes	Seasonally	Constantly
Alternating Sides				
Constant				
Daytime				
Nighttime				
All Year Round				
Seasonal (Check all that apply)	___ Winter	___Spring	___Summer	___Fall

4. Do your Eyes……

	Never	Sometimes	Seasonally	Constantly
Water				
Itchy				
Swollen				
Burn				

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5. Do you sneeze frequently?

	Never	Sometimes	Seasonally	Constantly
Year Round				
Seasonally				
Daytime				
Nighttime				

6. Do you cough?

	Never	Sometimes	Seasonally	Constantly
Year Round				
Seasonally				
Daytime				
Nighttime				

7. During what Months do you have the above symptom? (Check all that apply)

___ January	___ April	___ July	___ October
___ February	___ May	___ August	___ November
___ March	___ June	___ September	___ December

8. Which month do find these symptoms most severe? (Check all that apply)

___ January	___ April	___ July	___ October
___ February	___ May	___ August	___ November
___ March	___ June	___ September	___ December

9. How many colds do you usually have per year? ____________________

10. Have you ever smoked? If yes, please answer the following questions:
    a. How many cigarettes per day? __________
    b. How many cigars per day? __________
    c. How many times a day do you smoke a pipe? __________
    d. How many years have you been smoking? __________
    e. If you quit, when did you quit smoking? __________

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11. Do you have any pets or are exposed to pets on a regular basis?____Yes_____No
    a. _____ Cats, How Many? __________
    b. _____ Dogs, How Many? __________

12. Do you have any extreme reactions to insect bites? (Check all that apply)

    _____ Bees
    _____ Wasps
    _____ Spiders
    _____ Snakes
    _____ Ants
    _____ Other ___________________________

    a. Have you been hospitalized for this reaction?______Yes _____No

13. What type of dwelling do you live in and where is it located?

_____ Single House	_____ City
_____ Duplex	_____ Suburban
_____ Apartment	_____ Rural
_____ Trailer Home	_____ Farm

14. What prescription and non-prescription medications do you take on a regular basis?

    ____
    ____
    ____

15. What medications relieve your allergy symptoms?

    ____
    ____
    ____

16. Please use the space provided below to tell us anything you would like us to know about your allergy problems.

    ____
    ____
    ____