

*Please email this completed form 1 week prior to your visit to:* [*oconomowoc@lcped.com*](mailto:oconomowoc@lcped.com)

Allergy Questionnaire - Intake Questions

Patient’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s Birthdate: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Has he/she ever been diagnosed with asthma or bronchitis? \_\_\_\_Yes \_\_\_\_No

2. Has he/she every been diagnosed with eczema? \_\_\_\_Yes \_\_\_\_No

3. Has your child had tonsils or adenoids removed? \_\_\_Yes \_\_\_\_No

4. Has your child had ear, nose or sinus surgery? \_\_\_Yes \_\_\_\_No

If yes, please explain:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**All**ergy Questionnaire

1. What is your reason for coming to the clinic (main complaints, symptoms, problems)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. How often does he/she experience these symptoms? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. Does he/she have any of these symptoms:

Cough: \_\_\_\_Yes \_\_\_\_No

Runny Nose: \_\_\_\_Yes \_\_\_\_No

Nasal Polyps: \_\_\_Yes \_\_\_\_No

Eczema: \_\_\_Yes \_\_\_\_No

Wheezing: \_\_\_Yes \_\_\_\_No

Nasal Congestion: \_\_\_Yes \_\_\_\_No

Poor Sense of Smell: \_\_\_Yes \_\_\_\_No

Hives / Swelling: \_\_\_Yes \_\_\_\_No

Shortness of breath: \_\_\_\_Yes \_\_\_\_No

Itchy Nose: \_\_\_Yes \_\_\_\_No

Ear Infections: \_\_\_Yes \_\_\_\_No

Headaches: \_\_\_Yes \_\_\_\_No

Chest tightness: \_\_\_Yes \_\_\_\_No

Itchy / Watery Eyes: \_\_\_Yes \_\_\_\_No

Sinus Infections: \_\_\_Yes \_\_\_\_No

Snoring: \_\_\_Yes \_\_\_\_No

Sneezing: \_\_\_Yes \_\_\_\_No

Postnasal Drip: \_\_\_\_Yes \_\_\_\_No

Blocked Ears: \_\_\_\_Yes \_\_\_\_No

Fatigue: \_\_\_Yes \_\_\_\_No

Phlegm/sputum: \_\_\_Yes \_\_\_\_No

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4. Which of the following seems to bother or trigger/cause the above symptoms?

Grass: \_\_\_\_Yes \_\_\_\_No

Cats: \_\_\_Yes \_\_\_\_No

Cosmetics: \_\_\_Yes \_\_\_\_No

Drafts: \_\_\_Yes \_\_\_\_No

Nervousness: \_\_\_Yes \_\_\_\_No

Hay: \_\_\_Yes \_\_\_\_No

Dogs: \_\_\_Yes \_\_\_\_No

Aerosol sprays: \_\_\_Yes \_\_\_\_No

House Dust: \_\_\_\_Yes \_\_\_\_No

Cold Air: \_\_\_\_Yes \_\_\_\_No

Mold & Mildew: \_\_\_\_Yes \_\_\_\_No

Horses: \_\_\_\_Yes \_\_\_\_No

Perfumes: \_\_\_\_Yes \_\_\_\_No

Smoke: \_\_\_\_Yes \_\_\_\_No

Humidity: \_\_\_\_Yes \_\_\_\_No

Basements \_\_\_Yes \_\_\_\_No

Other Animals: \_\_\_\_Yes \_\_\_\_No

Insecticides: \_\_\_\_Yes \_\_\_\_No

Pollution: \_\_\_\_Yes \_\_\_\_No

Weather changes: \_\_\_\_Yes \_\_\_\_No

Leaves: \_\_\_\_Yes \_\_\_\_No

Latex (rubber): \_\_\_\_Yes \_\_\_\_No

Odors: \_\_\_\_Yes \_\_\_\_No

Exercise: \_\_\_Yes \_\_\_\_No

5. Please list the months symptoms are the worst. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

6. Are symptoms better away from home?: \_\_\_\_Yes \_\_\_\_No. If yes, when? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

7. List any food you suspect are causing symptoms, if any. Please list foods and reactions:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

8. Has your child ever had an allergy skin test or blood test? \_\_\_Yes \_\_\_\_No   
If yes, please supply results to us prior to your appointment.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

8. Have he/she ever had allergy injections? : \_\_\_\_Yes \_\_\_\_No. If yes, when? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

9. Is he/she on allergy medications? \_\_\_Yes \_\_\_\_No.

If yes:

What meds?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How much? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How long have they been taking? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Is patient...**

On beta blocker? \_\_\_Yes \_\_\_\_No

Significantly immunocompromised or have malignancy or severe chronic illness?   
\_\_\_Yes \_\_\_\_No

If yes to above, blood test will be performed.

Wheezing or having difficulty breathing? \_\_\_Yes \_\_\_\_No

Currently experiencing active hives or extensive dermatitis? \_\_\_Yes \_\_\_\_No

If yes to above, treat symptoms and schedule for another day

ENVIRONMENTAL SURVEY

1. How long have you lived in your house/apartment? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2.. What year was the home built? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. Do you live in:

City: \_\_\_\_Yes \_\_\_\_No

Suburbs: \_\_\_\_Yes \_\_\_\_No

Rural area: \_\_\_Yes \_\_\_\_No

4. Do you have a basement? \_\_\_Yes \_\_\_\_No

5. Type of heating:

hot air: \_\_\_\_Yes \_\_\_\_No

steam (radiator): \_\_\_\_Yes \_\_\_\_No

electric: \_\_\_\_Yes \_\_\_\_No

hot water (baseboard): \_\_\_Yes \_\_\_\_No

6. Do you have:

Wood /coal stove or fireplace: \_\_\_\_Yes \_\_\_\_No

Humidifier: \_\_\_\_Yes \_\_\_\_No

Dehumidifier: \_\_\_\_Yes \_\_\_\_No

Air cleaner: \_\_\_Yes \_\_\_\_No

7. Number of pets (indoor or outdoor) \_\_\_\_Cats \_\_\_\_Dogs \_\_\_\_Birds \_\_\_\_Other\_\_\_\_None

8. Are there any tobacco smokers in your home? \_\_\_Yes \_\_\_\_No

9. Is your child’s bedroom in the basement? \_\_\_Yes \_\_\_\_No

10. Does your child have allergy-proof encasing for pillow or mattress? \_\_\_Yes \_\_\_\_No

11. What type of pillows does he/she have? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

12. What type of comforter does he/she have? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

13. What type of floor covering is there in the child’s bedroom?

Wall to wall: \_\_\_\_Yes \_\_\_\_No

Area rug: \_\_\_\_Yes \_\_\_\_No

Animal skin: \_\_\_\_Yes \_\_\_\_No

Bare floor: \_\_\_Yes \_\_\_\_No

14. How old is the mattress? \_\_\_\_\_\_\_\_\_

15. Do you have air conditioning? \_\_\_\_Yes \_\_\_\_No

If yes, is it:

Window unit: \_\_\_\_Yes \_\_\_\_No

Central: \_\_\_Yes \_\_\_\_No

16. Do you have problems with roaches or mice? \_\_\_Yes \_\_\_\_No

17. Do you have water leaks, mold contamination? \_\_\_Yes \_\_\_\_No

18. Is your home/apartment excessively humid? \_\_\_Yes \_\_\_\_No

19. Does your child experience runny nose or sneezing in response to eating? \_\_\_Yes \_\_\_\_No

Family History:

Who in the family has had:

Asthma: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Eczema: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Seasonal /year-round allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sinus problems: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other allergies (drugs/bee sting/food etc):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***THANK YOU FOR YOUR TIME!***

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with the subject line: Allergy Testing Questionnaire.