Lake Country PEDIATRICS S.C.
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Allergy Questionnaire

Patient Name: _____ Date of Birth: _____Today's Date: _____

What allergies do you currently have concerns for? _____
What symptoms do you experience? _____
What is the frequency that symptoms occur? (i.e. daily, weekly, seasonally, etc.)
_____
What current medications and / or supplements are you taking?
_____
_____
_____
Has patient ever been tested for allergies before: ☐ Yes; Type: _____ ☐ No
Has patient ever had a strong reaction to any allergy treatment or testing: ☐ Yes; Type: _____
☐ No ☐ Not Applicable

Family Medical History:
Any major illnesses or conditions: ☐ Yes; Type: _____ ☐ No
Any family history of allergies: ☐ Yes; Type: _____ ☐ No
Alcohol and / or Tobacco Use:
Do you consume alcohol: ☐ Yes; Type/Frequency: _____ ☐ No
Do you use tobacco: ☐ Yes; Type: _____ ☐ No

Environmental Questionnaire:
Average hours spent a day in the following environments: Home: ___, Work: ___,
School: ___, Daycare: ___, Other: _____
How many years have you lived in / been going to building: Home: ___, Work: ___,
School: ___, Daycare: ___, Other: _____
Home location: ☐ city, ☐ residential, ☐ industrial, ☐ town, ☐ rural or farm
Do you have carpeting (shag, short pile, wall to wall, partial; & age) in your home?:
☐ Yes; Type: _____ ☐ No
Has there been water damage to buildings you / your child spend time in:
☐ Yes; Type: _____ ☐ No
Are there any significant dust or bug problems (roaches, etc.) in any building you/your child spend time in: ☐ Yes; Type: _____ ☐ No
Are you around any pets (dog, cat, bird, hamster, etc.): ☐ Yes; Type: _____ ☐ No
Any additional environmental comments: _____
Does anything in your environment make you feel unwell (list specific products or items AND describe your symptoms): ☐ Yes; Type: _____ ☐ No

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Miscellaneous Information:

How good is your sense of smell: ☐ Good ☐ Somewhat diminished ☐ Poor ☐ No sense

Do you feel worse certain times of the year: ☐ Yes; When: _____ ☐ No

Are you regularly exposed to livestock or crops / field work: ☐ Yes; Type: _____ ☐ No

How many days of work or school did you miss in the past year: ___ days - main reason why:

_____

What precautions do you take for perceived allergy problems (pillow covers, air cleaners, etc.):

_____

Please list any additional information here you would like us to know for environmental allergies:

_____

Diet / food questionnaire:

Do you have any known food allergies: ☐ Yes; Type: _____ ☐ No

List foods that seem to cause symptoms, describe symptoms that occur: _____

List any foods you avoid and why: _____

Do you or your child follow a special diet: ☐ Yes; Type: _____ ☐ No

How many meals a week do you eat at: home: ___, fast food restaurants: ___, other restaurants: ___, school (provided by school): ___, elsewhere: ___

What foods do you typically eat during: breakfast: _____, lunch: _____, and dinner: _____

What are your favorite three everyday meals: _____

Are you a vegetarian: ☐ Yes ☐ No

List the number of servings you eat each week from the categories below:

Category	None	1-3	4-6	7+
Wheat products				
Corn products				
Other grains				
Dairy products				
Yeast				
Red meats				
Other proteins				
Eggs				
Fruits				
Vegetables				
Peanut products				
Snack foods				
Beverages				

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Patient Information:

	Yes	No	Not Applicable
Did patient have colic as a baby?			
Was the patient breastfed exclusively?			
Was the patient formula fed?			
Any difficulty tolerating formula?			
Does patient have any chronic or recurring infections?			
Did the patient have any serious infections? (i.e. meningitis, pneumonia, etc.)			

Please list any additional information here you would like us to know for food allergies:

_____