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ALLERGY QUESTIONNAIRE

Please answer all questions. If not applicable, write N.A. Thank you.

Name _____ Age _____ Date _____

Address _____

Why were you referred to our office? _____

How did you hear about our practice? _____

What are two or three of your most bothersome symptoms? _____

Age when symptoms first occurred: _____ City and state _____

Symptoms are worse in which season? _____

Check those symptoms that you are having or have had:

NOSE	NOW	PAST	SINUSES	NOW	PAST
Nasal stuffiness	<input type="checkbox"/>	<input type="checkbox"/>	Headaches near eyes	<input type="checkbox"/>	<input type="checkbox"/>
Frequent sneezing	<input type="checkbox"/>	<input type="checkbox"/>	Post nasal drip	<input type="checkbox"/>	<input type="checkbox"/>
Itchiness	<input type="checkbox"/>	<input type="checkbox"/>	Colored nasal discharge	<input type="checkbox"/>	<input type="checkbox"/>
Clear nasal discharge	<input type="checkbox"/>	<input type="checkbox"/>	Sinusitis	<input type="checkbox"/>	<input type="checkbox"/>
Sniffling	<input type="checkbox"/>	<input type="checkbox"/>	Fevers	<input type="checkbox"/>	<input type="checkbox"/>
Frequent throat clearing	<input type="checkbox"/>	<input type="checkbox"/>	Night cough	<input type="checkbox"/>	<input type="checkbox"/>
Loss of smell or taste	<input type="checkbox"/>	<input type="checkbox"/>	Nasal polyps	<input type="checkbox"/>	<input type="checkbox"/>
EYES			ASTHMA		
Frequent tearing	<input type="checkbox"/>	<input type="checkbox"/>	Wheeze with:		
Redness	<input type="checkbox"/>	<input type="checkbox"/>	Exercise	<input type="checkbox"/>	<input type="checkbox"/>
Yellow discharge	<input type="checkbox"/>	<input type="checkbox"/>	Walking	<input type="checkbox"/>	<input type="checkbox"/>
Swelling of eyelids	<input type="checkbox"/>	<input type="checkbox"/>	Running	<input type="checkbox"/>	<input type="checkbox"/>
Pus in eyes	<input type="checkbox"/>	<input type="checkbox"/>	Breathing cold air	<input type="checkbox"/>	<input type="checkbox"/>
Itching	<input type="checkbox"/>	<input type="checkbox"/>	Colds	<input type="checkbox"/>	<input type="checkbox"/>
			Emotional upset	<input type="checkbox"/>	<input type="checkbox"/>
SKIN			Laughing	<input type="checkbox"/>	<input type="checkbox"/>
Eczema	<input type="checkbox"/>	<input type="checkbox"/>	Coughing	<input type="checkbox"/>	<input type="checkbox"/>
Hives (welts)	<input type="checkbox"/>	<input type="checkbox"/>			
Skin rash	<input type="checkbox"/>	<input type="checkbox"/>	When you wheeze do you have:	YES	NO
Swelling	<input type="checkbox"/>	<input type="checkbox"/>	Coughing	<input type="checkbox"/>	<input type="checkbox"/>
			Mucous production	<input type="checkbox"/>	<input type="checkbox"/>
EARS			Pain in chest	<input type="checkbox"/>	<input type="checkbox"/>
Stuffiness	<input type="checkbox"/>	<input type="checkbox"/>	Nasal stuffiness	<input type="checkbox"/>	<input type="checkbox"/>
Popping	<input type="checkbox"/>	<input type="checkbox"/>	A cold	<input type="checkbox"/>	<input type="checkbox"/>
Ear aches	<input type="checkbox"/>	<input type="checkbox"/>	Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>
Hearing loss	<input type="checkbox"/>	<input type="checkbox"/>			
Infections	<input type="checkbox"/>	<input type="checkbox"/>			
Fluid behind ear drums	<input type="checkbox"/>	<input type="checkbox"/>			

Have you ever been diagnosed with asthma or hay fever? Yes No

How many times have you had Serous Otitis (fluid behind the ear drums) in the last 12 months? _____

Have you consulted an E.N.T. physician for this? Yes No

Have you ever had "PE tubes" in your ears? Yes No

Have you ever broken your nose? Yes No

Check the statement which best describes your symptoms:

- Symptoms are clearly present but cause little or no discomfort.
- Symptoms are clearly annoying and cause some discomfort.
- Symptoms cause marked discomfort but do not interfere with sleep and/or daily routines.
- Symptoms are severe and interfere with sleep and/or daily routines.

How do your symptoms interfere with your daily routines? _____

Check those items you think make symptoms start or become worse:

- | | | |
|---|---|--|
| <input type="checkbox"/> Dry, clear weather | <input type="checkbox"/> In the basement | <input type="checkbox"/> Eating |
| <input type="checkbox"/> Wet, rainy weather | <input type="checkbox"/> House dust | <input type="checkbox"/> Alcohol |
| <input type="checkbox"/> Cold weather | <input type="checkbox"/> Tobacco smoke | <input type="checkbox"/> Exercise |
| <input type="checkbox"/> Change in weather | <input type="checkbox"/> Sudden chilling | <input type="checkbox"/> Excitement |
| <input type="checkbox"/> Increase in humidity | <input type="checkbox"/> Being in a draft | Being exposed to: |
| <input type="checkbox"/> Being in a wind | <input type="checkbox"/> Strong smells | <input type="checkbox"/> Dogs |
| <input type="checkbox"/> Being outside | <input type="checkbox"/> Hair sprays | <input type="checkbox"/> Cats |
| <input type="checkbox"/> Being inside | <input type="checkbox"/> Perfumes | <input type="checkbox"/> Birds |
| <input type="checkbox"/> Mowing the grass | <input type="checkbox"/> Newspaper ink | <input type="checkbox"/> Other animals _____ |
| <input type="checkbox"/> Raking leaves | <input type="checkbox"/> Paint fumes | <input type="checkbox"/> Insect sprays _____ |
| <input type="checkbox"/> In a musty room | <input type="checkbox"/> Cosmetics | |

Anything else: _____

Are you (B) better or (W) worse at: Home _____ Work _____ School _____

Do you smoke cigarettes? _____ How many per day? _____

Smoke anything else? _____ Does anyone in your house smoke? _____

How much alcohol to you drink? _____

Are you improved with air conditioning? _____ Made worse? _____

Please list all of your pets: _____

Do they stay indoors or outdoors? _____ Where do they sleep? _____

State age of your home _____ years. How long have you lived there? _____

Is your home in the Country or City? _____ What is your home around? (fields, farms, factories, etc.) _____

Do you own your home? _____ Rent? _____ Rent an apartment? _____

Was your home previously occupied? _____ Did the previous occupants have a pet? _____ What type? _____

What is your pillow stuffed with? _____ Your blanket? _____

Your mattress? _____ Your quilt? _____

What type of floor covering do you have? (vinyl, carpet, wood, etc.) _____

What type of backing or rug pad do you have? (foam, animal hair, fiber, etc.) _____

Do you keep books in your bedroom? _____ Do you have a storage area in your bedroom? _____

What is your furniture stuffed with? (list all) _____

Type of heating system _____ Type of cooling system _____

(Please check the box if the statement applies to you.)

- I have a humidifier.
- There is mold or mildew present in my home.
- I have house plants.
- I have an aquarium.
- A vaporizer is run often.
- A dehumidifier is used.
- I have a basement.
- Condensation is a problem.
- Standing water is present.

OTHER SYSTEMS OF THE BODY: (Please check the box if the statement applies to you.)

- I have a heart murmur or an irregular heart rhythm.
- I have other heart troubles.
- I have high blood pressure.
- I am on medication for high blood pressure.
- I have had a chronic gastrointestinal condition.
- I have had recent nausea, vomiting, or diarrhea.
- I have had hepatitis.
- Kidney or bladder infections are a problem for me.
- I have a chronic condition of the kidneys.
- I have had convulsions.
- I presently have a form of paralysis.
- I have had anemia or a condition of the blood.

Is there anything that we should know about your general health? _____

Please list all illnesses and surgeries you have had (dates and age): _____

DRUG ALLERGIES

Please list all drugs you may be allergic to and the symptoms they caused you to have (hives, rash, etc.): _____

Have you ever reacted to eggs? _____ Please describe _____

Have you ever reacted to feathers? _____ Please describe _____

FOOD ALLERGIES

Do you have any of these symptoms after eating any food? Itching of the lips and mouth _____ Hives _____ Facial rash _____
Headaches _____ Other Symptoms _____

How soon after eating food do symptoms occur? _____

Which foods caused these symptoms? _____

When you were an infant did you have an allergy to milk or other foods? _____

Do any members of your family have food allergies? _____

Do you eat: _____ Eggs _____ Milk _____ Cheese _____ Bananas

_____ Tomatoes _____ Fish _____ Shellfish _____ Chocolate

_____ Citrus fruits _____ Peanuts _____ Melons _____ Nuts (Tree)

Do any of the above make you sick? _____ What symptoms occur? _____

How soon after consumption? _____

INSECT ALLERGY

Have you ever had what you thought was an allergic reaction to an insect sting or a fire ant? Yes No

(If the answer is NO, please move to the section on contact allergy)

What were your symptoms? _____

Did you seek emergency treatment following the sting or bite? Yes No

Describe treatment: _____

Do you know what insect stung you? Yes No Please list: _____

Have you ever been treated in the Emergency Room or been hospitalized for a reaction you had to a food, an insect sting, or a medication? _____ Please explain _____

Has a physician ever prescribed an emergency kit for you? (Anakit, EpiPen, etc.) _____

CONTACT ALLERGY

Examples:

Poison Oak/ Ivy

Clothes

Perfume

Lotion

Shampoo

Materials

Soap

Jewelry

Detergent

Latex

Make-up

Do you or have you ever had a contact allergy to anything? _____

When was your first contact reaction? _____

Do you know what caused the reaction? _____

Describe the symptoms you had or have now _____

HIVES or ANGIOEDEMA (SWELLING)

Have you ever experienced hives/welts/ or angioedema? _____ (If the answer is NO, move to the next section)

When did the hives or angioedema first occur? _____

Are your hives or angioedema becoming worse or occurring more often? _____

What do you suspect is the cause, or can you relate this to a food or medication that you had taken? _____

What size are the individual hive lesions? _____

Please describe the angioedema: _____

When you break out in hives or angioedema, how long does it last? _____

Where on your body do hives break out most often? _____

Where does the angioedema occur on your body? _____

List the medications you take to control your hives or angioedema: _____

Cholinergic: Do any of these factors cause your hives or angioedema to start or worsen?

Heat Exercise Sweating Excitement

Hot baths Exertion Emotional upset

HIVES / ANGIOEDEMA (CONT'D)

Do you have any of the following symptoms associated with your hives or angioedema?

- | | | |
|------------------------------------|---|---|
| <input type="checkbox"/> Headache | <input type="checkbox"/> Listlessness | <input type="checkbox"/> Abdominal cramps |
| <input type="checkbox"/> Faintness | <input type="checkbox"/> Excessive sweating | <input type="checkbox"/> Diarrhea |

Psychogenic: Do you relate the onset of hives or angioedema to a particular episode of emotional upset? _____

Endocrine: Do you have any of the following symptoms?

- | | | |
|--|---|--|
| <input type="checkbox"/> Intolerance to heat or cold | <input type="checkbox"/> Change in skin or hair | <input type="checkbox"/> Thyroid trouble |
|--|---|--|

(Women) Are your hives or angioedema worse before or during your menstrual period? _____

Have your hives or angioedema ever occurred while you were pregnant? _____

Autoimmune; Serum sickness: Are you having any of these symptoms? (Check all boxes that apply)

- | | | |
|---|---|---|
| <input type="checkbox"/> Frequent fever | <input type="checkbox"/> Joint stiffness | <input type="checkbox"/> Enlarged lymph nodes |
| <input type="checkbox"/> Loss of weight | <input type="checkbox"/> Aching or swelling | <input type="checkbox"/> Muscle tenderness |

Physical factors: Do any of the following factors cause your skin to itch or burn?

- | | | | | | |
|-------------------------------|-------------------------------|--------------------------------|-----------------------------------|------------------------------------|-----------------------------------|
| <input type="checkbox"/> Cold | <input type="checkbox"/> Heat | <input type="checkbox"/> Water | <input type="checkbox"/> Sunlight | <input type="checkbox"/> Vibration | <input type="checkbox"/> Pressure |
|-------------------------------|-------------------------------|--------------------------------|-----------------------------------|------------------------------------|-----------------------------------|

PREVIOUS ALLERGY HISTORY

Have you seen an allergist before? _____ If so, when? _____

Were you allergy skin tested? Yes No Did you receive allergy injections? Yes No

Please list inclusive dates of your injections: _____

Were you helped? Yes No How so? _____

Why did you stop? _____

MEDICATION HISTORY

Please list all medications you are now taking: _____

Do you take aspirin? Yes No Or aspirin containing medications? Yes No

How often? _____ Do they make you ill? _____ In what way? _____

FAMILY AND SOCIAL HISTORY

PLEASE ANSWER ALL QUESTIONS:

Education: _____ Occupation: _____

Birthplace: _____ Marital status: _____

Hobbies: _____ Patient: _____

Spouse: _____

Children: _____

Others at home: _____

Family History

State age of	Father:	Mother:	Sisters:	Brothers:	Children:
<i>Do they have:</i>					
Hay fever					
Asthma					
Hives					
Eczema					
Sinusitis					

List illnesses which run in your family: (arthritis, diabetes, heart attacks, emphysema, migraines, glaucoma, etc.)

Comments:

FEMALES ONLY

Are you pregnant or nursing a baby? Yes No Do you have menstrual problems? Yes No
Are your symptoms worse at any particular time of your menstrual cycle? Yes No
Date of your last menstrual period: _____
Are you planning a pregnancy anytime soon? Yes No
Are you taking birth control pills? Yes No How long? _____

CHILDREN ONLY

Does your child stay in a nursery or at a day care center? Yes No
Does your child have a history of eczema? Yes No

PREGNANCY, LABOR, AND DELIVERY:

Were there any complications during pregnancy? Yes No
What was the birth weight? _____
Did the baby have trouble breathing shortly after birth? Yes No

FOOD HISTORY:

Was the child breast or bottle fed? _____
Are all foods tolerated? Yes No Which foods are not? _____
Is there coughing during or following feedings? _____

DEVELOPMENT:

At what age did child first sit alone? _____ first walk _____
Is your child developing normally? _____

IMMUNIZATION:

(Please check all immunizations your child has had.)

- "DPT" (diphtheria, tetanus, and whooping cough)
- Polio immunization
- MMR (measles, mumps, and rubella)
- Skin test for tuberculosis
- Hemophilus Influenza B (HIB)
- Pnuemovax (pneumonia vaccine)
- Hepatitis B vaccine
- Varicella (chicken pox) vaccine

Please note reactions to any of the above: _____

ADDITIONAL COMMENTS:

NOTE: Information in this questionnaire is a confidential part of your medical record and will only be released by your written authorization.

Signature of person filling out questionnaire _____
Date _____