Cockerell McIntosh PEDIATRICS
Taking Care of Children Since 1950!

# ALLERGY CLINIC-PATIENT QUESTIONNAIRE

NAME: ________________________________________ DOB: _________ TODAY'S DATE: __________

A. Please check any of the following problems which you have had, and record when they started:

**Problem/Date of Onset**

____ sniffles

____ nasal congestion

____ sneezing

____ runny nose

____ nose bleeds

____ sore throat

____ mouth breathing

____ snoring

____ itchy eyes

____ red eyes

____ watery eyes

____ itchy mouth or ears

____ diarrhea

____bloating

____ gas

____ formula problem

____ colic

____ other (please name)

**Problem/Date of Onset**

____chronic cough

____ recurrent cough

____ wheezing

____ recurrent colds

____ otitis media (middle ear infection)

____ bronchitis

____ headache

____ migraine

____ hives

____ eczema

____ dry skin

____ itchy skin

____ draggy feeling

____ hyperactivity

____ behavior prob

____ poor appetite

NAME: ______________________________________ DOB: _________ TODAY'S DATE: __________

B. Have you noticed that symptoms come on:

At any special time of day or night? Yes No
If yes, when?

At all times of the year? Yes No
If yes, which months are worse?

Only at a particular time of the year? Yes No
When?

In any particular room of the house? Yes No
Which one?

At work/At school? Yes No
If yes, are there materials, dusts, or fumes which bring on or increase your symptoms?

What symptoms are present almost daily?

C. Please check which of the following make your symptoms worse.

____ dusting house ____ flowers ____ vacuuming

____ raking leaves ____trees ____ basement

____ tobacco smoke/wood smoke ____ grass ____ exercise

____ aspirin

____ other medication (which?)

____ foods (which?)

____others (please name)

NAME: ________________________________________ DOB: _________ TODAY'S DATE: __________

D. Pollen Allergies:

____ aggravated outdoors

____ aggravated on windy days

____ improved in air-conditioning

E. Mold Allergies:

____ worse in damp places

____ worse when mowing or playing on grass

____ caused by raking leaves

F. Dust/Mite/Animal/Mold Allergies:

____ aggravated indoors

____ worse 30 min after going to bed

____ worse in the winter

____ nasal symptoms with little eye involvement

____ bothered by central air conditioning

G. Previous treatment:

| | | |
|---|---|---|
| Have you inquired about allergy treatment in the past? | Yes | No |
| Have you ever been treated for allergy in the past? | Yes | No |
| Have you ever received occasional "allergy shots" or steroids for hayfever? | Yes | No |
| Have you received desensitizing treatment? | Yes | No |
| Have you taken antihistamines? | Yes | No |

Please name them all (including over the counter brands).

NAME: ______________________________________ DOB: _________ TODAY'S DATE: __________

Have you used nasal sprays or eye drops for allergy? Yes No
Please name them.

Have you ever used asthma medications, such as inhalers/ breathing machines? Yes No
If yes, please name the medication used.

What soap do you use when bathing?

What detergent/fabric softener do you use?

If you have eczema, what medications have you tried?

H. Medications:
Do you ever take aspirin or ibuprofen or acetaminophen? Yes No
If so, how frequently?

I. Hospitalizations:
Have you ever been admitted to the hospital for any reason? Yes No
If yes, please record how times and why:

J. Family History:
Do (or did) any of your family members receive treatment for allergy? Yes No

Do they now or did they in the past suffer from any of the symptoms mentioned at the beginning of this

history form? Yes No
If yes, please record the symptoms by the appropriate person.
Mother:

Father:

Brother:

Sister:

NAME: ________________________________________ DOB: _________ TODAY'S DATE: __________

J. Family History Continued:

Grandparent:

Grandparent:

K. Do you own your own home? Yes No

How old is your home?

Is there mildew in your home? Yes No

Construction of home: Frame _____ Brick _____ Block _____ Other

Type of heating

Central Air? Yes No

Do you have a humidifier? Yes No

Attic fan? Yes No

What kind of floor covering?

Do you have a basement? Yes No
If yes, how is it used?

Do you sleep in the basement? Yes No

Does anyone in your family smoke? Yes No
If yes, who?

Is there any smoking in your home or car? Yes No

Do you use/own any product filled with feathers or down? Yes No

Pillow_____ Coat_____ Vest_____ Comforter_____

Thank you for your patience, please continue……

NAME: ________________________________________ DOB: _________ TODAY'S DATE: __________

K. Continued

Do you have pets in your home (including fish)? Yes No

Please list:

Are you exposed to any other animals? Yes No

Animals in the classroom? Yes No

Do you own or ride horses? Yes No

Do you want to be tested for any animal other than dog and cat? Yes No

Guinea pig_____ Rabbit_____ Cattle_____ Goat_____ Horse_____ Birds_____

Other

Do you attend a basement schoolroom? Yes No

L. Expectations:

Please describe what you hope to achieve during this office visit:

List three (3) questions you would most like to have answered:

1.

2.

3.

Use this space to record any other relevant (or possibly relevant) information, **including a list of all current medications and dosage:**

Thank you for your patience, please continue……

NAME: _________________________________________ DOB: _________ TODAY'S DATE: __________

**FOOD ALLERGY – NUTRITIONAL QUESTIONNAIR**
**PLEASE READ EACH QUESTION CAREFULLY.**
**THEN CHECK YES OR NO TO INDICATE YOUR ANSWER. IF YES, PLEASE EXPLAIN.**

**Yes_____** **No_____** 1. Are there any foods or beverages that you a) crave or b) eat frequently? List

a) b)

**Yes_____** **No_____** 2. Are there any foods or beverages that you dislike? List example.

**Yes_____** **No_____** 3. Do you eat snacks frequently between meals? List examples.

**Yes_____** **No_____** 4. Did you have any problems with food when you were a child? Please describe:

**Yes_____** **No_____** 5. Do you have problems with any foods now? Name them:

**Yes_____** **No_____** 6. Were you breastfed, or what formula were you given?

**Yes_____** **No_____** 7. Do you experience belching, abdominal distention, bloating or cramps following meals?

**Yes_____** **No_____** 8. Are you awakened between the hours of 1:00 AM and 5:00 AM with the following symptoms?

Headache_____ Dizziness_____ Stomach cramps______ Bloating_____

Dry cough_____

**Yes_____** **No_____** 9. Do you or any member of your family have:

Hayfever_____ Asthma_____ Hives_____ Chronic skin condition_____

Migraines______ Headaches_____ Colitis_____

**NAME: ________________________________________DOB: _________ TODAY'S DATE: __________**

**Yes_____ No_____ 10.** During childhood did you have any of the following:

Eczema_____ Hayfever_____ Asthma_____ Food feeding problems_____

**Yes_____ No_____** 11. Do you have itching of the:

Skin_____ Palate_____ Roof of your mouth_____ Skin rash_____

**Yes_____ No_____** 12. Do you frequently notice swelling of your

Ankles_____ Feet_____ Hands_____ Face_____

**Yes_____ No_____** 13. Do you have marked fatigue two or three hours after meals?

**Yes_____ No_____** 14. Do you have excessive chilling when a sudden change in temperature occurs?

**Yes_____ No_____** 15. Do you have frequent headaches or "Migraines"?

**Yes_____ No_____** 16. Do you have alternating constipation or diarrhea?

**Yes_____ No_____** 17. Do you have joint or muscle pain or stiffness?

**Yes_____ No_____** 18. Do you have fluctuating vision?

**Yes_____ No_____** 19. Do you have recurring fungal infections?

Vaginitis_____ Athlete's foot_____ Jock itch_____ Ring worm_____