



Kaiser Foundation Hospitals
The Permanente Medical Group, Inc.

ALLERGY QUESTIONNAIRE

IMPRINT AREA

PLEASE ANSWER ALL QUESTIONS ACCURATELY. THE INFORMATION IS VERY IMPORTANT FOR YOUR TREATMENT.

Name: _____ Age: _____

Medical Record Number: _____

Occupation: _____ Which doctor sent you: _____

PLEASE CIRCLE YOUR SYMPTOMS AND COMPLAINTS:

Chest	Nose	Ears	Eyes	Throat	Skin	Other
Asthma	Hay fever	Itching	Itching	Itching	Itching	Headache
Cough	Congestion	Blockage	Tearing	Hoarseness	Hives	Fatigue
Wheeze	Sneezing	Frequent infection	Swelling	Voice loss	Eczema	Loss of appetite
Excess mucus	Running	Discharge	Redness	Frequent infection	Infection	Loss of weight
Tightness	Bleeding	Hearing Loss	Blurring vision	Post nasal drip	Rash	
Shortness of breath	Itching	Ear aches	Styes	Soreness		
Frequent Infections	Polyps		Mattering	Dryness		
Congestion	Loss of smell			Bad breath		
	Discharge					

Which symptoms cause you the most concern? _____

When did your symptoms begin? _____ Month _____ Year _____

In what city or area were you when you first experienced your symptoms? _____

Are your symptoms worse any particular time of the year? If so, which month: _____

Worst month(s)? _____ Best month(s)? _____

Frequency of attacks? Daily _____ Weekly _____ Monthly _____

What time of day or night are symptoms worse? _____

Duration of symptoms? _____

Longest period symptom-free without medication? _____

Progression: Are symptoms becoming better? _____ Worse? _____ Same? _____

Read the following list carefully and indicate by checking (x) in the appropriate boxes to the left of each item, which items cause or aggravate, relieve or have no apparent effect upon your allergy symptoms. Even a small change is significant.

Cause or Aggravation	Relieve	No Change	ITEM:
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lawn mowing, grass contact
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Weed contact, specify: _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Blossoming trees, specify: _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Raking leaves
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Musty, moldy or mildewed places or articles
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Going indoors
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Wind
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sweeping, dusting, vacuuming in house, dusty books, etc.
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Any animals, specify: _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Emotional upset
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Laughing
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Exertion or heavy exercise, specify: _____
<hr/>			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory infection
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Insect spray
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hair spray, cosmetics, talcums, aftershaves, perfumes, etc., specify: _____
<hr/>			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Air conditioning, swamp coolers, etc., specify: _____
<hr/>			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Temperature changes _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tobacco smoke
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Antihistamines, specify: _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nasal decongestants, specify: _____
<hr/>			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Wheezing Medications (as Tedral, Amesec, etc.) Specify: _____
<hr/>			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Aspirin
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Adrenalin or Susphrine
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Steroids (Cortisone type drugs), specify: _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other drugs, including sprays, cold medicines, patent medicines, etc., specify: _____
<hr/>			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Trips to the mountains
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Trips to the desert
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Trips to the seashore
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Any other trips out of this area, specify place and time of year: _____
<hr/>			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Menstrual periods
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pregnancy
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Anything else you have noticed, specify: _____
<hr/>			
<hr/>			

Name: _____ M.R.# _____

Have you ever had any of the following conditions, if so check the appropriate boxes and specify during which years (and if applicable, seasons) and in what area you were living at the time.

- Hay fever
- Nasal allergy all year ("sinus")
- Asthma (wheezing, shortness of breath) describe: _____

- Hives, urticaria, angioedema (facial swelling, etc.)
- Eczema
- Skin rash due to allergy or contact, specify: _____
- Poison oak, ivy or sumac rash, specify: _____
- Food Allergy, specify foods and what symptoms they cause. Specify and describe any other unusual reaction when you eat any particular food: _____

Have you ever had a reaction or allergy to any drug or medication? _____
List drugs, reactions they cause, and date reactions occurred. _____

Do you have more than 3-4 "colds" per year? If so, how many? _____
Are you prone to frequent infection? _____ If so, list type and frequency: _____

How much school or work has been missed in the past year because of allergy? _____
Have you had a severe reaction to a bee, wasp or hornet sting? _____
Describe: _____

PLEASE COMPLETE IF PATIENT IS A CHILD. The following concerns infancy or childhood.
(Questions 1 through 8)

Were there:

1. Problems at birth? (Circle) Prematurity, breathing problems, infection, other: _____

2. In the first year of life (Circle) Bellyache, colic, or excessive crying after three months of age.
3. Breast fed? Yes No. For how long? _____
4. Formula change more than once the first 3 months of life. Yes No
5. As an infant (Circle) Excessive gas, spitting, loose stools, blood in stools.
6. In the first year (Circle) Chest congestion, rattling in chest or bouts of wheezing.
7. In the first year (Circle) Repeated colds or ear infections.
8. Other significant health problems in the first year? Describe: _____

PAST MEDICAL HISTORY:

Have you had any of the following in the past (or currently)? If so, please check the appropriate box and give approximate years, etc.

- Tuberculosis _____
- Pneumonia, pleurisy _____
- Heart disease of any kind _____
- High or low blood pressure _____
- Ulcer of the stomach or duodenum _____
- Liver disease, hepatitis _____
- Urinary or kidney problems _____
- Arthritis – type, if known _____
- Thyroid disease, low or high, specify: _____
- Diabetes _____
- Anemia or blood problems _____
- Mental or emotional or nervous problems _____
- Cancer, tumor, growths _____

Please circle diseases you have had: Measles, German measles, Chickenpox, Mumps, Whooping Cough.

- Hospitalizations for allergy and asthma. Please specify below:

Date:	Hospital:	Physician:
_____	_____	_____
_____	_____	_____

- Other hospitalizations for illness or operations (including tonsillectomy [T&A]). Please specify year and diagnosis:

- Serious injuries (specify and date): _____

- Other illnesses (specify and date): _____

FAMILY HISTORY:

Relative	Living or deceased	Age now or at death	Health (Good, Fair, Poor)	Allergies (List)	Other diseases including diabetes, tuberculosis
Father:	_____	_____	_____	_____	_____
Mother:	_____	_____	_____	_____	_____
Brothers:	_____	_____	_____	_____	_____
Sisters:	_____	_____	_____	_____	_____

Are you married? _____

Spouse's Health: (Good/Fair/Poor): _____

Spouse's Occupation: _____

Number of Children: _____

Their state of health: _____

Their allergies: _____

If patient is a child – Mother's Occupation: _____

Father's Occupation: _____

Name: _____ M.R.# _____

MEDICATIONS:

List all medications currently used (for any reason) and frequency of use (Include vitamins, birth control pills, aspirin, laxatives).

DRUG	FREQUENCY
_____	_____
_____	_____
_____	_____
_____	_____

Have you ever used any cortisone drug? Yes No

Have you used any of the following? (Circle) Prednisone, Cortisone, Aristocort,
Medrol, Kenalog, Celestone, Deltasone, Stemex, Hexadrol, Decadron.

Dates first and last used: _____

Frequency of use: _____

List drugs used in the past for treatment of allergies: _____

DIET:

Are you on a special diet? If so, please specify: _____

WORK EXPOSURE: (Where applicable)

Year in school: _____

If college, major: _____

1. Job Title: _____

2. Years performed: _____

3. Are you exposed to dusts, odors, fumes or smoke? _____

If so, which? – please describe:

4. Does your work affect your allergy?

If so, in which way?

Where were you born? _____

List all the places you have lived for more than 6 months and how long you have lived there?

Area	Duration
_____	_____
_____	_____
_____	_____
_____	_____

How long have you lived in the Bay Area? _____

How long have you lived at your present address? _____

Do you smoke tobacco? Yes No Type _____ Daily amount _____

How many years? _____

If no – Are you exposed to smoke
in the home? Yes No
workplace? Yes No

What pets are you exposed to:

at home _____

at frequently visited home _____

school/babysitter _____

Have you been studied or treated by an allergist in the past or has any other physician done allergy skin tests or given you injections for allergy: Yes No Specify years and details (Skin tests, allergy shots and results of treatment).

ADDITIONAL SIGNIFICANT HISTORY TO BE NOTED BY PHYSICIAN _____

