

Ear, Nose and Throat Consultants
Allergy Questionnaire

Name: _____

Date: _____

Circle all that apply

Do you have a history of?

Asthma YES NO : How often do you use your rescue inhaler? _____

Ever been hospitalized for severe attack? _____

Beta-Blockers YES NO : Which medications do you take? _____

MAO-inhibitors YES NO : Which medications do you take? _____

Severe Allergic Reaction or Anaphylaxis? YES NO

Ever been hospitalized for allergic reaction? YES NO

Recurrent sinus infections? YES NO : How many a year? _____

Recurrent ear infections? YES NO : How many a year? _____

Check all the apply

Does your nose feel?

	Never	Sometimes	Seasonally	Constantly
Stuffy				
Runny				
Itchy				
Post-Nasal drip				

Do your ears feel?

	Never	Sometimes	Seasonally	Constantly
Full/Plugged up				
Itchy				
Sore/Painful				
Wet/Have discharge				

Does your eyes?

	Never	Sometimes	Seasonally	Constantly
Water				
Itch				
Swell/Feel Swollen				
Burn				

Name: _____

Date: _____

Do you sneeze frequently?

	Never	Sometimes	Seasonally	Constantly
Year round				
Seasonally				
Daytime				
Nighttime				

Do you cough frequently?

	Never	Sometimes	Seasonally	Constantly
Year round				
Seasonally				
Daytime				
Nighttime				

Which months do you find your allergy symptoms are most severe? _____

How many colds do you usually have per year? _____

Do you smoke? YES NO : How much? _____

Are you around other people that smoke? YES NO : How often? _____

Do you have any pets or are you exposed to any animals? Specify: _____

Do you have extreme reactions to insect bites? _____

What type of housing do you have?

Single House _____ Duplex _____ Apartment _____ Condo _____ Other: Specify _____

When was it built? _____

Where is it located? City _____ Suburban _____ Rural _____ Farm _____

What medications relieve your allergy symptoms?

Do you have any food allergies? YES NO Specify: _____

Ever been allergy tested? YES NO

Is there a family history of allergies? YES NO If yes, specify who: _____

Reviewed by : _____ MD