

# Kids Allergy Center ALLERGY QUESTIONNAIRE

To be filled out by the parent/guardian of the minor child. The following questions will help to determine the cause of your allergy symptoms. It is important to check (☐) each question to the best of your knowledge and as accurately as possible.

**Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_ **Age:** \_\_\_\_\_

**Date:** \_\_\_\_\_ **Date - Last Antihistamine:** \_\_\_\_\_

**Previous Allergy Workup: (Yes / No) Year Tested?** \_\_\_\_\_ **Immunotherapy?** \_\_\_\_\_

**Referring Physician:** \_\_\_\_\_

*Please check what applies to you:*

**General:**

- Weight: Gain or Loss
- Tired all the time

**Skin:**

- Rash (where \_\_\_\_\_)
  - soap
  - contact
- Hives
- Eczema, boils, infections
- Dryness, itching
- Insect bite reaction

**Head:**

- Headache (where \_\_\_\_\_)
- Head injury (when \_\_\_\_\_)

**Eyes:**

- Strain, change in vision
- Redness, puffiness, discharge
- Itching, rubbing

**Ears:**

- Pain, discharge
- Itch, popping
- Infections, hearing loss

**Nose:**

- Frequent colds
- Discharge
  - Clear / Discolored
  - Thin / Thick
  - Constant / Seasonal
- Itching, rubbing, picking
- Stuffiness (constant / seasonal)
- Sneezing
- Sniffling, snoring, bleed
- Change in smell

**Throat:**

- Sore, itch
- Trouble swallowing
- Clearing throat, hoarseness
- Post nasal drip (clear/ white/ other)

**Respiratory:**

- Wheeze (with rest / with activity)
- Cough (day/ night, with exercise)
  - Dry  Wet
- Chest tightness
- Shortness of breath

**CONTINUE →**

**Patient Name** \_\_\_\_\_

**Symptoms:**

Symptoms worse:  indoor,  outdoor,  home,  work,  morning,  afternoon,  night

Symptoms worse in what season:  Winter,  Spring,  Summer,  Fall

**Symptoms Triggers:**

- smoke,  perfume,  hair spray,  paint,  cosmetics,  insecticides,  chemicals,
- fumes,  detergent,  hay,  grass,  dust,  damp areas,  animal (specify \_\_\_\_\_),
- food (specify \_\_\_\_\_),  alcohol,  cold day,  hot day,  windy day,  weather change,  air conditioning,  intense laughing or crying
- medication (specify \_\_\_\_\_)

**Living Accommodations:**

**House or**  **Apartment** (age of building \_\_\_\_ ) Present address for \_\_\_\_ years.

Location:  city,  suburb,  country/farm.  Recent painting or repairs.

Slab/basement:  finished,  dry,  damp,  mildew

Flooring:  hardwood, carpet -  wool,  synthetic, padding -  rubber,  ozite,  other

**Furniture:**  new,  mohair

**Window treatment:**  drapes,  blinds,  shades

**Heating system:**  hot air,  hot water,  electric baseboard.

Fuel:  gas,  electric,  coal,  oil,  other \_\_\_\_\_

Air filters:  fiberglass,  electrostatic,  HEPA,  other \_\_\_\_\_

Air conditioning:  central,  window unit.  Humidifier,  Dehumidifier

Use of ceiling fans: Y\_\_ N\_\_

Usual house temperature: \_\_\_\_ Day \_\_\_\_ Night

Bedroom windows open:  day,  night,  winter,  summer

**Bedding:** Mattress -  regular,  synthetic,  waterbed. Mattress cover -  cotton pad,

allergy proof. Box spring cover -  cotton,  allergy proof. Pillows -  feather,

polyester,  kapok. Blanket -  wool,  cotton,  synthetic,  other \_\_\_\_\_.

Comforter -  cotton,  Down,  other \_\_\_\_\_.

**Pets:**  cat,  dog,  bird,  other. Frequent contact -  in house,  access to bedroom

**Infestation:**  cockroach,  mouse,  rat

**Smoking:**  patient,  family member,  work,  other

**Work Environment:**

Occupation \_\_\_\_\_

Office,  factory,  outdoor,  other \_\_\_\_\_

Exposure:  smoke,  fumes,  chemicals,  other \_\_\_\_\_

**Medical History:**

Emergency room visit or hospital stays in last 12 months. Specify \_\_\_\_\_

Diagnosed with any other disease in the last 12 months. Specify \_\_\_\_\_

Are currently on allergy shots

Previous reaction to allergy shots. Specify \_\_\_\_\_

**CONTINUE** →

**Patient Name** \_\_\_\_\_

**Past Medical History:**

Disease	Patient	Father Side	Mother Side	Sibling
Asthma				
Hay Fever				
Eczema				
Hives				
Food Allergy				
Drug Allergy				
Frequent/Many Infections				
Sinus Infection				
Ear Infection				
Bronchitis				
Pneumonia				
Migraine				
Other Significant: _____	_____	_____	_____	_____

**Drug Reactions: Yes / No**

Date/Drug	Symptoms	Last taken:

**Food Reactions: Yes / No**

Date/Food	Symptoms	Can eat now

**Immunizations:**

Childhood immunizations completed:  Yes  No

Last Flu shot \_\_\_\_\_

Reaction to immunizations:  Yes Specify \_\_\_\_\_  No

Questionnaire completed by: \_\_\_\_\_ (Printed Name)

Signature: \_\_\_\_\_