Proliance
South Seattle
Otolaryngology

Allergy Intake Questionnaire

Patient name: _____ DOB: _____ Today's Date: _____

1. PATIENT HISTORY

   a. When did your allergy symptoms begin (please mark one):

      Infancy ____ Childhood ____ Teens ____ Age ____ or Year ____

   b. How long have lived in the area? _____

   c. Do you plan to stay in the area? _____

   d. What areas are most affected by your allergies (circle all that apply):

      Eyes Ears Nose Throat Lungs Skin GI Symptoms

      Please describe what symptoms you experience that are most bothersome: _____

      _____

2. ALLERGIC HISTORY

   a. Have you been diagnosed or treated for eczema? If so, what treatment? _____

   b. Have you been diagnosed or treated for asthma? If so, what treatment? _____

   c. Do you have any of these symptoms (circle all that apply)?

      Wheezing Nighttime cough Restricted breathing Shortness of breath Itchy Skin

   d. Do you have any food allergies? If so, what? _____

   e. Do you have venom allergies or latex allergies? Yes No

3. ENVIRONMENTAL EXPOSURES

   a. What exacerbates your symptoms (circle all that apply)?

      Outdoors Indoors At home At work Animals

   b. Are there environmental exposures that tend to exacerbate your symptoms (ie. Perfumes, air conditioning etc.)? _____

c. What season are your symptoms worst? (circle all that apply)

Spring Summer Fall Winter

d. What type of flooring do you have (ie. Carpet, hardwoods, etc.)? _____

e. What type of pillow, comforter, or mattress do you use (ie. Feather, down, etc.)?
_____

f. Do you have HEPA filters or an air filtration system? Yes No

g. Do you have air conditioning and if so what type? _____

h. Do you have vapor barrier under your house? Yes No Unsure

i. Do you have animals in your home (or regular exposure), and if so, what type? _____

j. Where do you live? (Circle all that apply)

Home Apartment Rural Suburban Urban

4. MEDICATION HISTORY

a. What medications have you used in the past for your allergies?

Name: _____ Did it work? _____ How long did you use it? _____

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Name: _____ Did it work? _____ How long did you use it? _____

5. FAMILY HISTORY

a. Does anyone in your immediate family have allergies, asthma, or eczema? _____

b. Has anyone undergone allergy testing or immunotherapy? _____

6. IMMUNOTHERAPY HISTORY

a. Have you ever had an anaphylactic reaction? Yes No Unsure

b. Have you ever had allergy shots, drops or tablets? Yes No Unsure

If so, when, where , and for how long? _____