The Vancouver Clinic

Allergy, Asthma & Immunology Questionnaire

Please bring this completed form to your first appointment

Name _____ DOB _____ Sex _____

1. INSTRUCTIONS: A complete accurate record is important in learning about your allergy problem.

Describe the reason for your allergy visit. Please include questions/concerns you want addressed:

2. ENVIRONMENTAL REVIEW

☐ Apartment/house/mobile home [circle]:

Approximate age of home _____ Years at current home _____

☐ Bedroom carpeted ☐ Area rugs in bedroom

☐ Hardwood floor in bedroom ☐ Electric wall heaters

☐ Forced air heat/Heat pump ☐ Radiator

☐ Bedroom A/C ☐ Central A/C

☐ No A/C ☐ Bedroom humidifier

☐ HEPA unit in bedroom

☐ Tobacco smoke in home ☐ Basement

☐ Other 2nd hand tobacco exposure _____

☐ Mold growth in home (window sills, bathroom, walls)

☐ Hay dust exposure ☐ Occupational exposures

☐ Feather (down) pillow/comforter

☐ Cat ☐ Dog ☐ Other animals _____

☐ Pets allowed in bedroom ☐ Pets restricted from bedroom

☐ Pets strictly outdoors ☐ Pets exposure at friends

3. PREVIOUS ALLERGY EVALUATION AND THERAPY

Have you ever had allergy tests? ☐ Yes ☐ No ☐ Skin tests ☐ Blood tests

If yes, give date _____ Physician's Name _____

Have you ever received allergy injections? ☐ Yes ☐ No Did they help? ☐ Yes ☐ No

If yes, give dates _____

Please list all medication and treatments you have taken for allergies in the PAST:

Did they help? ☐ Yes ☐ No Length of use? _____

4. PROBLEMS

Type	Check all boxes that apply Leave blank if not applicable	Severity			Age at onset
		Mild	Moderate	Severe	
Asthma (Wheezing)	☐ Cough				
	☐ Wheezing				
	☐ Shortness of breath				
	☐ Exercise induced asthma				
	☐ Decreased exercise tolerance				
	☐ Chest tightness				

Problem	Check all boxes that apply Leave blank if not applicable	Severity			Age at onset
		Mild	Moderate	Severe	
Cough	☐ Episodic throughout day				
	☐ Night time awakening				
	☐ Nocturnal cough				
	☐ Typical cold causes asthma				
	☐ Chest pain				
	☐ Sputum production [circle] Clear/Yellow/Green				
Nasal Allergy (Hay fever)	☐ Itchy nose				
	☐ Runny nose [circle] Clear/White/Yellow/Green				
	☐ Sneezing				
	☐ Stuffy nose				
	☐ Sniffling				
	☐ Post nasal drainage [circle] Constant/Periodic/Occasional/Triggers cough				
	☐ Decreased sense of smell				
Sinus Problems/Sinusitis	☐ Facial pressure				
	☐ Headaches				
	☐ Sinusitis requiring antibiotics				
	☐ Seasonal sinusitis Months typicall affected _____				
	☐ Cold triggered sinusitis Months typicall affected _____				
Throat Symptoms	☐ Throat clearing				
	☐ Hoarseness				
	☐ Dry mouth				
	☐ Sore throat				
Eye Allergy	☐ Increased tearing				
	☐ Itchiness				
	☐ Redness				
	☐ Puffy eyelids				
	☐ Dark circles under eyes				
Ear Symptoms	☐ Fullness sensation				
	☐ Popping sounds				
	☐ Decreased hearing				
	☐ Ear infections				
	☐ Problems with air travel				
Eczema	☐ Eczema in childhood				
	☐ Lotions				
	☐ Steroid cream				
	☐ Dermatology evaluation				
Food Allergy	List _____				
Insect Reactions	List _____				

Problem	Check all boxes that apply Leave blank if not applicable	Severity			Age at onset
		Mild	Moderate	Severe	
Hives [circle all descriptions that apply] itchy flat raised can occure anywhere on body causes bruising causes pain single spots come and go	☐ Hives occuring with swelling				
	☐ Hives occuring without swelling				
	☐ Triggered by medications List _____				
	☐ Triggered by foods List _____				
	☐ Triggered by exercise List _____				
	☐ Triggered by water [circle] Hot/Cold				
	☐ Triggered by cold temperature				
	☐ Triggered by scratching				

5. SYMPTOMS Check all boxes that apply. Leave blank If not applicable.

Seasonal Pattern to Nasal and Eye Allergy Symptoms

☐ Year long with seasonal worsening
Specify worst seasons _____

☐ Year long without seasonal changes

☐ Only seasonal Specify months _____

☐ Seasonal problems [Circle] nasal allergy/eye allergy/asthma/ sinus infection

☐ Seasons asthma worsen _____

☐ Seasons eczema worsen _____

Infections

☐ Never occurs ☐ Pneumonia ☐ Triggered by a cold ☐ Occurs seasonally
When _____

Absenteeism from school or work

☐ Never occurs ☐ Rarely occurs ☐ Seasonally affected
When _____

Number of days missed last year Work ____ School ____

General review of past history [specify year]

☐ Broken nose _____ ☐ Nasal Surgery _____ ☐ Tonsillectomy _____ ☐ Adenoidectomy _____

☐ Ear tubes _____ ☐ Acid Relux _____ ☐ Sleep Apnea _____ ☐ CPAP_____ ☐ Yes ☐ No

☐ Urgent Care for asthma _____ ☐ Hospitalization for asthma _____

General Symptoms

☐ Poor sleep ☐ Fatigue ☐ Snoring ☐ Mouth breathing

6. TRIGGERS

☐ Cutting grass ☐ Time around cats ☐ High winds ☐ Work Fumes/Chemicals

☐ Raking leaves ☐ Time around dogs ☐ Change of seasons _____

☐ Moldy areas ☐ Time around horses ☐ Weather changes ☐ Cleaning solutions

☐ Damp areas ☐ Time around rabbits ☐ Cold air ☐ Dust during cleaning

☐ Excercise ☐ Other animals ☐ Indoor worse than out ☐ Strong odors

☐ Tobacco smoke _____ ☐ Outoor worse than in _____

7. REVIEW OF SYMPTOMS

Are you <u>currently</u> experiencing problems with the following

☐ Skin problems ☐ Intestinal problems

☐ Eye problems ☐ Skin problems

☐ Ear/Throat infections ☐ Kidney or bladder

☐ Chronic lung disease ☐ Psychiatric or depression

☐ Heart or HBP ☐ Diabetes or thyroid

☐ Blood problems

Physician's Notes

☐ Dr. Caruthers ☐ Dr. Owens ☐ Dr. Srinivasan Date _____