*Lone Star ENT & Allergy*

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**Allergy Testing Questionnaire**

*PRINT PLEASE*

Today’s Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Local Pharmacy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(for epi-pen)

Have you been Allergy Tested before? YES / NO

If yes, when: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ where: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Did you take treatment? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Why are you needing Allergy Testing? *circle ALL symptoms that apply*

Wheezing Hearing Loss Snoring

Sneezing Shortness of Breath Congestion

Loss of Smell Post-Nasal Drainage Bad Breath

Loss of Voice Headaches Eczema

Runny Nose Frequent Clearing of Throat Fatigue

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are your allergy symptoms year-round or seasonal? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do your symptoms flare up often? YES / NO

How long do your flare ups usually last? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*(minutes, hours, days, weeks, etc)*

Are your symptoms worse during a certain time of day? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*(morning, evening, etc)*

Are your symptoms worse during certain seasons? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*(spring, summer, fall, winter)*

Are you diagnosed with Upper Respiratory Infections more than 3 times per year? YES / NO

Do you have pets? \_\_\_\_\_\_\_\_\_\_\_\_ If yes, what kind? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How long have you lived in this area? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How long have you lived at your current residence? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Did you have your current allergy symptoms at your previous residence? YES / NO

Do you have a Family History of Asthma? YES / NO

Have you been diagnosed with Asthma? YES / NO If yes, at what age? \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you taken/used any of the following medications within the last week? *circle ALL that apply*

Antihistamine/Allergy Medication Sleep Aid/Tylenol PM, Etc Eye Drops

Blood Pressure Medication Inhalers Decongestants

Nose Spray Cough Syrup/Drops Antidepressant

Blood Thinner Motion Sickness Medication Antacids

Have you had an Allergic Reaction that caused any of the following: *circle ALL that apply*

Hives Swelling of the Throat Difficulty Breathing Swelling of the Face

What caused the reaction circled above? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever been Food Allergy Tested? YES / NO

If no, would you like to be tested today? YES / NO

If treatment is necessary which option do you feel like you would prefer? Shots / Drops

(Shots are weekly / Drops are monthly)