New Hope Medical Clinic
704-824-4560

Allergy Questionnaire

To be filled out at initial screening

Patient Name ______________________ Date of Birth ______________________

Reviewed by ______________________ Today's Date ______________________

1. Do you experience any of these symptoms more than twice per year: Cough, cold, congestion, headaches, difficulty breathing, wheezing, runny nose, sore throat, itchy/irritated eyes, sinus pain, ear pain, unexplained fatigue, skin irritation, snoring? ❑ Yes ❑ No
2. Have you ever been diagnosed with asthma or bronchitis? ❑ Yes ❑ No
3. Do you experience symptoms of allergies? ❑ Yes ❑ No

IF YOU ANSWERED YES TO ANY OF THE ABOVE QUESTIONS, CONTINUE BELOW.

4. Please check any symptoms that you suffer from ...

❑ Cough	❑ Runny Nose	❑ Nasal Polyps	❑ Eczema
❑ Wheezing	❑ Nasal Congestion	❑ Poor Sense of Smell	❑ Hives / Swelling
❑ Shortness of breath	❑ Itchy Nose	❑ Ear Infections	❑ Headaches
❑ Chest tightness	❑ Itchy / Watery Eyes	❑ Sinus Infections	❑ Snoring
❑ Sneezing	❑ Postnasal Drip	❑ Blocked Ears	❑ Fatigue
❑ Phlegm/sputum (Color__________)		❑ Other______________	

5. Which of the following seems to bother or trigger/cause the above symptoms?

❑ Grass	❑ Cats	❑ Cosmetics	❑ Drafts
❑ Nervousness	❑ Hay	❑ Dogs	❑ Aerosol sprays
❑ House Dust	❑ Cold Air	❑ Mold & Mildew	❑ Horses
❑ Perfumes	❑ Smoke	❑ Humidity	❑ Basements
❑ Other Animals	❑ Insecticides	❑ Pollution	❑ Weather changes
❑ Leaves	❑ Latex (rubber)	❑ Odors	❑ Exercise

❑ Insect bites/stings. Describe reaction: ______________________

❑ Foods. List foods and reactions: ______________________

❑ Other. List sources and reaction: ______________________

6. When are symptoms worst? ❑ Year round

❑ January	❑ February	❑ March	❑ April
❑ May	❑ June	❑ July	❑ August
❑ September	❑ October	❑ November	❑ December

7. Are symptoms better away from home? ❑ Yes ❑ No If yes, when? ______________________
8. Have you ever had an allergy skin test or blood test? ❑ Yes ❑ No
   If yes, results: ______________________
   Doctor's name and phone: ______________________
9. Have you ever had allergy injections? ❑ Yes ❑ No If yes, when? ______________________
10. Have you received cortisone (prednisone, methylprednisolone, etc.) drugs? ❑ Yes ❑ No
    If yes, when? ______________ How much? ______________________
11. Are you on allergy medications? ❑ Yes ❑ No What meds? ______________________
    How much? ______________ For how long? ______________________

Is the patient recommended to have an allergy test? ❑ Yes ❑ No

Inhalant Panels: ❑ Skin Test ❑ Blood Test **Food Panels:** ❑ Skin Test ❑ Blood Test

Schedule test for: ❑ Today ❑ Other ______________________

Refer patient to a specialist ❑ Yes ❑ No

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