AUCKLAND ALLERGY SPECIALISTS

ALLERGY QUESTIONNAIRE

Today's Date:

Patient's Name:

Date of Birth: Age:

Address: Phone:

Primary Care Physician

Name: Phone:

Address: **Email**

Referring provider, if different from primary care physician:

Name: Phone:

Address: Fax:

Email

1. **CHIEF COMPLAINT (reason for visit):**

2. **PRIOR ALLERGY EVALUATION AND TREATMENT:**

   Have you been previously evaluated for allergies? Yes ☐ No

   (***If yes, complete this section)***

   Have you ever had an allergy skin test? Yes ☐ No

   If yes, Date: **Results**

Have you ever had an allergy blood test? Yes No

If yes, Date:

Results:

Have you ever received immunotherapy (allergy shots)? Yes ☐ No

If yes, Dates: **What allergens**

3. FOOD REACTIONS: Yes ☐ (***If yes, complete this section)*** No

Are you on any special diets? Yes No **Avoiding any foods?** Yes No

If yes, please list in the table below:

Food	**Age Avoided**	**Symptoms**	**Still Avoiding?**

Do you have itching in your mouth after eating raw/fresh fruits or vegetables (i.e. bananas, melons, apples, peaches, pears, kiwi, citrus, tomato, potato), shellfish, peanut, or tree nuts? Yes ☐ No ☐

If yes, please list specific food triggers and age of onset:

4. ASTHMA HISTORY: Yes ☐ No ☐ (***If yes, complete this section)***

Age of onset: Frequency of attacks: Most recent exacerbation:

Have you ever needed any of the following for asthma? (Please answer with the most recent first.)

Hospital admissions: Yes No

Emergency room visits: Yes No

ICU admissions: Yes No

Intubations: Yes No

Symptoms: Wheeze ☐ Cough ☐ Sputum ☐ Exercise Intolerance ☐
Chest Pain ☐ Shortness of breath ☐

Night time cough: Yes ☐ No ☐

Season worse in: Winter ☐ Spring ☐ Summer ☐ Fall ☐

Triggers:

5. ALLERGY & ASTHMA TRIGGERS: (Please select choices, check "Yes" or "No", and list symptoms)

	Yes	No	Symptoms
Grass exposure	☐	☐	
Tree exposure	☐	☐	
Raking leaves ☐ Mowing lawn ☐	☐	☐	
Damp areas with mold and mildew	☐	☐	
Sweeping ☐ Dusting ☐ Vacuuming ☐	☐	☐	
Smog ☐ Air Pollution ☐	☐	☐	
Temperature changes (hot ☐ cold ☐)	☐	☐	
Tobacco smoke	☐	☐	
Exercise	☐	☐	

Animals (cats, dogs, etc…)	☐	☐
Coughing after drinking cold or hot water	☐	☐
Colds (Virals URI's)	☐	☐
Cleaning agents, fumes, perfumes	☐	☐
Others:	☐	☐

6. **INSECT ALLERGY: Yes** ☐ **No** ☐ ***(If yes, complete this section)***

Insect: Unknown ☐ Honeybee ☐ Yellow jacket ☐ Wasp ☐ Hornet ☐ Fire ant ☐

Symptoms:

☐ Local swelling	☐ Generalized swelling	☐ Hives
☐ Pain	☐ Wheezing	☐ Shortness of breath
☐ Throat tightening	☐ Difficulty swallowing	☐ Loss of consciousness

7. **LATEX ALLERGY: Yes** ☐ **No** ☐ ***(If yes, complete this section)***

Date	**Source**	**Reaction**

8. **MEDICATIONS** **Very Important question**

Please list **ALL medications,** including any **herbal or alternative medications,** that you are **currently taking (including dosage and frequency):** **If none please write "NONE"**

Nasal Spray: Rhinocort Flonase Nasocort Nasonex

Veramist Astelin Afrin Other

Inhalers: ☐ Salbutamol or Bricanyl ☐ Flixotide ☐ Symbicort ☐ Pulmicort ☐ Qvar
☐ Seretide ☐ Vannair ☐ Breo Ellipta ☐ Other:

If yes, when, and at what dose & frequency? Last time used:

9. MEDICATION/DRUG REACTIONS: Yes ☐ No ☐ ***(If yes, complete this section)***

Date	**Drug**	**Reaction**	**Taken Since**	
			Yes	No
			Yes	No
			Yes	No
			Yes	No

10. HISTORY OF REPEATED INFECTIONS: Yes ☐ No ☐ ***(If yes, complete this section)***

Type	**Date**	**Antibiotic needed**	**Abnormal tests (i.e. Chest X-rays/ CT Scans/Blood tests)**
Ear Infections			
Sinusitis			
Pneumonia			
Bronchitis			
Meningitis			
Dental Infections			
Bladder/Kidney Infections			
Skin Infections			
Joint Infections			
Gastrointestinal Infections			

11. OTHER MEDICAL/SURGICAL HISTORY: (Please answer all items)

A. List other medical illnesses:

B. Any surgeries:

C. Any ER visits/hospitalizations? For respiratory or allergic reactions? When?

What treatment did you receive?

D. For women, are your menstrual periods regular? Yes ☐ No

Number of days in typical cycle:

12. IMMUNIZATIONS:

A. Are your immunizations up to date? Yes ☐ No

B. Which immunizations listed below have you received?

☐ Diphtheria	☐ Rubella	☐ Prevnar
☐ Tetanus	☐ Polio	☐ Pneumovax
☐ Measles	☐ HIB	☐ Meningococcal
☐ Mumps	☐ Hepatitis B	☐ Varicella

C. Please list any adverse reactions to any immunizations:

D. Did you receive the influenza (flu) shot during the most recent or current flu season?
Yes ☐ No

E. Do you plan to obtain the flu shot for the upcoming season? Yes ☐ No

13. FAMILY HISTORY: (please complete)

Mother's health: age:
Father's health: age:
Brother(s)' health: age:
Sister(s)' health: age:

Do any family members have a history of the following? ***(If yes, please chack all that apply)***

Illness	**Yes**	**No**	**List Relatives (indicate if outgrown and when)**
Asthma	☐	☐	
Frequent Bronchitis	☐	☐	
Frequent Pneumonia	☐	☐	
Cystic fibrosis or Other Lung Disease	☐	☐	
Hay fever/ Allergic rhinitis	☐	☐	
Chronic Sinus problems	☐	☐	
Hives/ Urticaria	☐	☐	
Eczema	☐	☐	
Migraines	☐	☐	
Insect Allergy	☐	☐	
Drug Allergy	☐	☐	
Food Allergy	☐	☐	
Celiac Disease	☐	☐	
Immune disorders	☐	☐	
Autoimmune disorders (Lupus, thyroid disease, Rheumatoid arthritis)	☐	☐	
Inflammatory bowel disease	☐	☐	
Early unexplained death in infancy	☐	☐	
Frequent miscarriages	☐	☐	

14. ENVIRONMENTAL SURVEY:

A. Approximately how old is your home? How long have you lived there?

B. Is your home a(n): ☐ single family home ☐ brownstone/townhouse ☐ apartment

C. Does your home have:

☐ Central AC ☐ Window AC ☐ Wall Unit AC ☐ HVAC (heat & AC) wall unit
☐ Forced heat ☐ Radiator heat ☐ Gas heat ☐ Electric heat
☐ Humidifier ☐ Damp areas ☐ HEPA filter

D. Do your windows have: ☐ curtains ☐ drapes ☐ shades ☐ blinds

E. Does your **bedroom** have: ☐ wall-to-wall carpeting ☐ hardwood flooring ☐ area rugs

F. Where is your bedroom located? (floor or level of house)

G. On your bed, are there:

☐ Stuffed toys ☐ Dust mite proof covers ☐ Feather pillows
☐ Synthetic pillows ☐ Mattresses ☐ Weekly washing of bed linens

H. Do you have any pets (cats, dogs, birds, gerbils, hamsters, etc)? Yes No

I. If you have pets, do they enter your child's ☐ bedroom and/or Bed

J. Are there any pet animals at school or work? Yes ☐ No

K. Have you seen any pests in your home? Yes ☐ No
If yes, which pests? cockroaches ☐ mice ☐ rats ☐ Other:

L. Are you a smoker? Yes ☐ No

M. Are there any other smokers in the home? Yes ☐ No

N. What is your occupation?

O. Other environmental or occupational exposures? Yes ☐ No

P. Are your symptoms worse at school/work than at home? School /work Home

Q. Are there **any other locations(s)** where the symptoms are worse?

R. How many days have you missed school/work because of asthma or allergies?

15. COMMENTS: (Are there any other issues you would like to discuss at your visit?)

Signature of Patient/Legal Guardian Date

For the Physician: Reviewed & Confirmed: Date of Visit:

Race and Ethnicity Information

We want to make sure that all our patients get the best care possible. We would like you to tell us your child's racial and ethnic background as well as your preferred language so that we can review the treatment that all patients receive and make sure that everyone gets the highest quality of care. You may decline to answer if you wish.

The only people who see this information are registration staff, administrators for the practice, your care providers, and the people involved in quality improvement and oversight, and the confidentiality of what you say is protected by law.

Please mark the appropriate response:

Primary Language

- ☐ English
- ☐ Maori
- ☐ Tongan
- ☐ Fijian
- ☐ Samoan
- ☐ Japanese
- ☐ Mandarin (Chinese)
- ☐ Portuguese
- ☐ Slovak
- ☐ Tagalog
- ☐ Vietnamese
- ☐ Declined
- ☐ American Sign Language
- ☐ Bosnian
- ☐ Croatian
- ☐ French
- ☐ Hindi
- ☐ Korean
- ☐ Romanian
- ☐ Spanish
- ☐ Thai
- ☐ Yiddish
- ☐ Unknown
- ☐ Arabic
- ☐ Cantonese (Chinese)
- ☐ ECH
- ☐ German
- ☐ Indonesian
- ☐ Latin
- ☐ Persian
- ☐ Russia
- ☐ Swahili
- ☐ Turkish
- ☐ Yugoslavian
- ☐ Armenian
- ☐ Danish
- ☐ Greek
- ☐ Italian
- ☐ Malay
- ☐ Polish
- ☐ Serbian
- ☐ Swedish
- ☐ Urdu
- ☐ Other

Race

- ☐ White
- ☐ Maori
- ☐ Pacific Islander
- ☐ Mixed
- ☐ Asian
- ☐ Native Hawaiian or Other Pacific Island
- ☐ Other Combination Not Described

Ethnicity

- ☐ New Zealander
- ☐ Maori
- ☐ Declined

Pacific Islander

Samoan

Pharmacy Information

So that you and your physician may take advantage of e-prescribing, we need you to provide information on the pharmacy that you choose to use to fill you or your child's prescriptions. Electronic prescription requests are more efficient, accurate and cost effective. Feel free to speak with your physician if you have additional questions.

☐ New

Date:

Patient Name:

PRIMARY

Pharmacy Name:

Address:

Phone Number:

Fax Number:

SECONDARY (if applicable)

Pharmacy Name:

Address:

Phone Number:

Fax Number: