Auckland Allergy Specialists

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Auckland Allergy Specialists
97 Grafton Rd
Auckland 1010

PATIENT QUESTIONNAIRE

Date:

Name:

Parents name if patient is a child:

D.O.B.

Gender:

Ethnicity:

Mobile:

Address:

Email:

Communication preference:

General Practitioner's Name:
GP's Address:

Have you been referred by a doctor ?: Yes ☐ No ☐
Doctor's Name:

Medical Insurance: Yes ☐ No ☐
Insurance Company's Name:

List your main symptoms or concerns (with duration):

List all the medication you take: (*including inhalers, herbal, vitamins, etc)* If none, please say none

Drug history:

- Are you sensitive/allergic to any drugs Yes ☐ No ☐
- Which ones (s)?
- What was the reaction you had?

Were you treated in hospital for the reaction? Yes No

Answer all the following questions by ticking yes or no, or by writing brief comments:

- Have you had allergy tests before ? _____Yes ☐ No ☐
- Have you had immunotherapy before? _____Yes ☐ No ☐

What allergen(s) did you test positive to?

Anaphylaxis

This is the most serious type of allergic reaction. It can progress very quickly and may cause death without proper medical attention e.g. sudden severe collapse/shock, after food/drugs or any cause

- Have you ever had an ANAPHYLACTIC REACTION? Yes ☐ No ☐ I don't know ☐
- Was your anaphylaxis diagnosed by a doctor? Yes ☐ No ☐
- What was the cause? _____
- Do you carry an adrenaline autoinjector like Epipen? Yes ☐ No ☐

More about your allergic condition:

- Is your condition seasonal? Yes ☐ No ☐
- If so, which season is worst? Spring Summer Winter
- How often do you have your attacks? daily or more frequent
- How long do they last? Minutes Hours Days

Exercise history:

- Are your symptoms brought on or worsened by exercise? Yes ☐ No ☐

Allergic history:

Do you suffer from asthma? Yes ☐ No☐ was it diagnosed by a doctor? Yes ☐ No ☐
Do you suffer from eczema? Yes ☐ No ☐ was it diagnosed by a doctor? Yes ☐ No ☐
Do you suffer from Hay Fever? Yes ☐ No ☐ was it diagnosed by a doctor? Yes ☐ No ☐
Do you suffer from "sinus troubles? Yes ☐ No ☐
Do you suffer from Hives (Urticaria)?Yes ☐ No☐ was it diagnosed by a doctor? Yes ☐ No ☐
Do you get frequent 'colds'? Yes ☐ No☐
Do you suffer from a persistent cough? Yes ☐ No ☐
Do you suffer from abdominal cramps? Yes ☐ No ☐
Do you suffer from diarrhoea? Yes ☐ No ☐

If you have asthma:

When was it diagnosed? by Whom? Doctor

What treatment do you take for asthma (if none, say none)? Other

Do you use an inhaler every day? Yes ☐ No ☐

General medical history:

- Have you ever had an operation on your sinuses? Yes ☐ No ☐
- Do you have high blood pressure? Yes ☐ No ☐
- Are you diabetic? Yes ☐ No ☐
- Are you pregnant? Yes ☐ No ☐

Childhood allergic history:

- Did you have asthma? Yes ☐ No ☐
- Did you have eczema? Yes ☐ No ☐
- Did you have runny nose (rhinitis) / hay fever? Yes ☐ No ☐
- Did you have hives? Yes ☐ No ☐
- Did you have vomiting, diarrhoea, or colic? Yes ☐ No ☐

Family history: ***have any of your first degree relative (i.e. Parents or siblings) had:***

- Asthma? Yes ☐ No ☐ Mother Father Sibling
- Eczema? Yes ☐ No ☐ Mother Father Sibling
- Hay Fever? Yes ☐ No ☐ Mother Father Sibling

Food history:

- Have you ever been told by a doctor that you have a food allergy? Yes ☐ No ☐
- Do you suspect any foods as causing symptoms? Yes ☐ No ☐
- Which one's
- Are you omitting any food(s) at present? Yes ☐ No ☐

  Which one's

Environmental history:

- Do you have a cat? Yes ☐ No ☐
- Do you have a dog? Yes ☐ No ☐
- If close contact with any other animal, which one?
- Is your home carpeted? Yes ☐ N ☐
- Are your symptoms better on holidays? Yes ☐ No ☐
- Do you have any hobbies Yes ☐ No ☐

  What are your hobbies?

Occupational history:

- What is your current occupation?
- How long have you been in this job? Years Months
- Are your symptoms worse at work? Yes ☐ No ☐

Contact allergy:

Have you ever had a skin reaction to jewellery Yes ☐ No ☐
products/cosmetics Yes ☐ No ☐

Have you ever had a patch test? Yes ☐ No ☐

If yes, what allergens did you react to?

Please bring any photos of your skin rash, or copies of any tests results you have had for your current problem. or upload here

Upload Photos here

So that your doctor could take advantage of **e-prescribing,** kindly provide the information of the pharmacy you would like your prescription sent:

Pharmacy Name:

Address: