VALLEY ENT
EAR, NOSE, THROAT & ALLERGY

ALLERGY HISTORY QUESTIONNAIRE

Name:_____ DOB:_____ Today's Date:_____

PLEASE CIRCLE AND FILL IN THE APPROPIATE BLANKS AND ANSWER ALL QUESTIONS

Do you have a family history of allergies? YES or NO

What is your most bothersome symptom?_____

Is there a worse time of day for your symptoms? MORNING AFTERNOON EVENING

What season(s) is(are) worse for you? WINTER SPRING SUMMER FALL

What do you do for a living? _____

Is your house OLD NEW

Does your house have carpet? YES NO

Do you live in TOWN or in the COUNTRY? If in the country, what are your surroundings? _____

Do you have any pets? YES or NO If so, what pets? And are they indoor or outdoor?_____

Would you say when you go out of town your symptoms improve? YES or NO?

Do you or have you ever be diagnosed with asthma? YES NO

If yes, when is the last time you used your inhaler? _____

Do you have any allergies to any medications? YES NO

If yes, please list: _____

List any medication you are currently taking, including any OTC medications, Antihistamines, Vitamins or eye drops:

_____

Is there a possibility you are pregnant or considering? YES NO

Have you ever been allergy tested? If so, when? _____

Have you ever been on weekly allergy shots? YES NO

If yes, did they help? YES NO

Have you ever had a whole-body, life-threatening allergic reaction? YES NO

If yes, please describe the reaction_____

Do you or anyone in your home smoke? YES NO

Do you have a needle phobia? YES NO If so, how severe?_____

Signature of the patient, if not a minor_____