Allergy Dept.
Redding ENT Head & Neck Surgery, Inc.
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Allergy Questionnaire

NAME:_____ **DATE:**_____

ALLERGY HISTORY

1. Briefly describe the symptoms that brought you here._____
   _____
2. How long have you had these symptoms?_____
3. Are the symptoms worse:
   At home? θ No θ Yes Where?_____
   At work? θ No θ Yes Occupation?_____
   How about weekends? Better? Worse?
   Other locations(list):_____
   _____
4. Where are the symptoms worse? θ Indoors θ Outdoors
5. When are the symptoms worse? θ Spring θ Summer θ Fall θ Winter
   θ All same?
6. When are the symptoms worse? θ Morning θ Evening θ Night θ After meals?
7. Have you been tested for allergies? θ No θ Yes
   How?_____
   When?_____
   Where?_____
8. Have you any other active disease? θ No θ Yes. Please list:_____
   _____
9. Are you on any medications? θ No θ Yes. Please list:_____
   _____
   _____
10. Are you around animals? θ No θ Yes. Please list:_____
    _____

MOLD

Outdoors: θ Better θ Worse

1. Do your symptoms flare when the sun goes down? θ No θ Yes
2. Do you have trouble just before a thunderstorm? θ No θ Yes
3. Do you have trouble in dark woodlands? θ No θ Yes
4. Do you have trouble around lakes or marshes? θ No θ Yes

5. Do you have symptoms with lawn and garden work? θ No θ Yes
6. Do you have trouble around farms and barns? θ No θ Yes
7. Do you have increased symptoms when grain is being harvested in your area?
θ No θ Yes

Indoors: θ Better θ Worse

1. Do you have indoor green plants? θ No θ Yes. How many?_____
In what rooms?_____
2. Do you have a library of old books? θ No θ Yes
3. Do you have antique furniture? θ No θ Yes
4. Do your symptoms flare in the basement? θ No θ Yes
5. Do your symptoms flare in storage places? θ No θ Yes
6. Does your house have areas prone to moisture, such as around plumbing or air conditioners?
θ No θ Yes Please list:_____
7. Do you have heavy foliage against your house? θ No θ Yes
8. Do you have increased trouble in certain rooms of your house? θ No θ Yes
If yes, which ones?_____
9. What type of pillow do you use?_____
10. Do you use an open fireplace? θ No θ Yes

POLLEN

1. Are your symptoms worse when you go outside in the morning? θ No θ Yes
2. Do you have marked tearing and itching of the eyes when your symptoms are bad?
θ No θ Yes
3. Do you have bouts of repeated sneezing? θ No θ Yes
4. Rate your allergy symptoms for each month of the year (0-10 scale--- 0 no symptoms, 10 most severe)
January _____ February_____ March_____ April _____ May _____ June _____
July _____ August _____ September _____ October_____ November_____ December_____
5. Have you had itching of the skin with your symptoms? θ No θ Yes
6. Do you suspect a plant that gives you trouble? θ No θ Yes Please list:_____
_____
7. Are there areas of the country where your symptoms are especially bad? θ No θ Yes
If so, what areas? _____ What seasons in these areas?_____
8. Are there areas of the country where you have no symptoms? θ No θ Yes Please list:_____
_____
9. Do you have itching of your throat? θ No θ Yes

PERENNIALS

1. Is your house difficult to dust because of knickknacks? θ No θ Yes
2. Do you have overstuffed or antique furniture? θ No θ Yes
3. Does your nose congest shortly after you go to bed? θ No θ Yes
4. Do your symptoms flare in public buildings? θ No θ Yes
5. Do your symptoms increase in motels? θ No θ Yes
6. Do your symptoms flare in airplanes? θ No θ Yes
7. Does house cleaning flare your symptoms? θ No θ Yes
8. How old is your home?_____

9. Do you have a dog or cat? θ No θ Yes What type? _____
10. Did a previous occupant of your home have a dog or cat? θ No θ Yes
What type?_____
11. Do you have any other pets? θ No θ Yes What type? _____
12. Do you have trouble in public libraries or bookstores? θ No θ Yes

FOOD

1. Do your symptoms occur without regard to season? θ No θ Yes
2. Do they occur anywhere you are in the country? θ No θ Yes
3. How long do your symptoms usually last?_____
4. Do you have itching of your throat? θ No θ Yes
5. Do you have headaches? θ No θ Yes Where in the head?_____
6. Do you have intermittent skin rashes? θ No θ Yes Where on the body?_____
How long do they last?_____
7. Do you have cramping, bloating, or diarrhea often? θ No θ Yes
8. Do you tend to retaste food eaten earlier? θ No θ Yes
9. Do your symptoms wake you at night? θ No θ Yes When? _____
10. Are you excessively sleepy after meals? θ No θ Yes