Advanced ENT & Allergy

Penn Medicine Ear, Nose and Throat | Affiliate

ALLERGY QUESTIONNAIRE

(for allergy and asthma patients only)

Patient Name: ______________________________ Date of Birth: ______________

PAST ALLERGY HISTORY

Name of previous allergist: ______________________________ When seen? ______________

Did you ever have allergy shots or drops? ☐ Yes ☐ No

If yes, when did you start shots? ______________________ Stop shots? ______________________

Allergy test results, if known: ____

ENVIRONMENTAL HISTORY

Housing: ☐ House ☐ Apartment

How old is the home? ______________________________ Length of stay? ______________

Damp basement? ☐ Yes ☐ No

Known mold issues? ☐ Yes ☐ No

Pets: ☐ Yes ☐ No

Kind: ______________________________ How many? ______________

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Cockroaches in home/work? ☐ Yes ☐ No

Does anyone in the home smoke? ☐ Yes ☐ No

Heating: ☐ Forced air ☐ Baseboard ☐ Radiator ☐ Wood-burning stove ☐ Other: ______________

Air Conditioning: ☐ Central ☐ Window unit

Humidifier? ☐ Yes ☐ No

Dehumidifier? ☐ Yes ☐ No

Bedroom Floor: ☐ Carpeting ☐ Hardwood ☐ Area rugs ☐ Other: ______________________

Who lives at home with you? ____

Are there other households you stay at frequently?
(Example: weekends at grandmother's who smokes and owns a cat)

____

What kind of work do you do? ____

Are there any environmental exposures you are concerned about (Example: solvents at work)?

____

OTHER ALLERGY HISTORY

Food: ______________________________

Insect stings: ______________________________

Medications: ______________________________

FAMILY HISTORY (Indicate relationship to problems listed below. Examples: mother and sister.)

Asthma: ______________________________

Nasal allergies: ______________________________

Sinus problems: ______________________________

Eczema/rashes: ______________________________

Urticaria/hives: ______________________________

Recurrent infections and immune problems: ______________________________