Allergy Questionnaire

Name **Date:**

Age

Occupation

Address

Phone **Email**

Do you have Medical Insurance? Yes/ No

Referred by:

Examined by:

CHIEF COMPLAINTS OR MAIN SYMPTOMS:

1) Running nose: Yes / No

Perenial ___ Seasonal ____ If Seasonal, which season: Summer/Winter/Monsoon/Spring

Worst Month _____ Duration _____

2) Sneezing: Yes / No

3) Nose block: Yes / No

4) Cough: Yes / No

Dry _____ Wet _____ Paroxysmal (intermittent) _____ Continuous _____

Morning _____ Evening _____ Night _____ Going to bed _____ Any time _____

Duration _____

Sputum: Yes / No

Yellow _____ White _____ Mucoid _____ No smell _____ Fowl smell _____

5) Breathlessness (Dyspnoea): Yes / No

Exertional _____ Paroxysmal _____ Continuous _____

If Paroxysmal dyspnoea:

Perenial ___ Seasonal ____ If Seasonal, which season: Summer/Winter/Monsoon/Spring

Worst Month _____ Duration _____

6) Other complaints:

Do you suffer from skin allergy (Urticaria)? Yes No

Do you suffer from Diarrhoea? Yes No

Do you suffer from Abdominal Cramps? Yes No

7) Timing of symptoms, e.g. day, night, seasonal, at work, at home

Is your condition seasonal? Yes /No

If so, which season is worse?

How often do you have your attacks?

How long do they last?

The patient's perception of precipitating factors

ENVIRONMENTAL HISTORY

More outdoors / indoors

More at home / office / garden / on roads / specify

More in dust / smoke /fumes /

Home Environment: pets, carpet in bedroom, mildew

Do you have a Cat? Yes / No

Do you have a Dog? Yes / No

Are your symptoms better on Holidays? Yes / No

Are you worse at Work? Yes No

Work Environment: e.g. chemicals, irritants

FOOD HISTORY

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)

DRUG HISTORY

Are you sensitive / allergic to any Drugs? Yes / No

Which one(s)

EXERCISE HISTORY

Are your symptoms brought on or worsened by Exercise? Yes / No

Physical Agents: Cold _____ Fan _____ Moisture _____ Rains _____

Change of season _____

CHILDHOOD ALLERGIC HISTORY

Did you have Asthma (Yes / No), Eczema (Yes / No), runny nose (Rhinitis) (Yes / No) in childhood?

FAMILY HISTORY

Have any of your family (father/ mother/ son/ daughter/ sister/ brother/ grand father/ grandmother) had:

Asthma? Yes No Relationship

Eczema? Yes No Relationship

Rhinitis? Yes No Relationship

GENERAL MEDICAL HISTORY

Have you ever had an operation on your Sinuses? Yes No

Do you have High Blood Pressure? Yes No

Are you a Diabetic? Yes No

Are you Pregnant? Yes No

Do you Smoke? Yes No

TREATMENT HISTORY:

List ALL medicines you take (including herbal, vitamins, etc.):

Have you had Allergy Tests before? Yes No

Have you had Immunotherapy (desensitisation) before? Yes No

Have you ever had a severe reaction to a Bee or Wasp sting? Yes No

How did this reaction manifest itself?

Have you ever had an Anaphylactic Reaction? Yes No

(Sudden severe collapse/shock after food, drugs or any cause.)

What was the cause?

PRESENT FINDINGS:

NOSE:

Septum:

Inferior turbinates:

Middle turbinates:

Osteomeatal Complex:

Adenoids:

Mucopus:

Paranasal Sinuses:

THROAT:

Post nasal drip:

Tonsils:

Pharynx:

Respiratory System:

ANY PAST INVESTIGATIONS:

Blood:

TC /DC / AEC:

Serum Ig E:

Nasal smear:

X Rays: Chest **PNS**

CT Scan:

ADVICE:

Skin Prick Tests: **Yes No**

Nasal Smear: **Yes No**

Blood Investigations: **Yes No**

Nasal Endoscopy: **Yes No**

CT PNS: **Yes No**

PROVISIONAL DIAGNOSIS:

Rhinitis : Allergic / Non-allergic

Allergic Rhinitis : **Mild / Moderate / Severe**

Intermittent / Persistent

Hyper-responsive airway: **Yes No**

Allergic Bronchitis (Asthma): **Yes No**

Urticaria: **Yes No**