

NEW PATIENT ALLERGY QUESTIONNAIRE

Name _____ Age _____ Sex M F
 Occupation _____ Date _____

Current history

Symptoms (please tick)

NOSE	EARS	EYES	MOUTH/THROAT	ASTHMA/CHEST
<input type="checkbox"/> blocked	<input type="checkbox"/> itching	<input type="checkbox"/> itchy	<input type="checkbox"/> mouth breathing	<input type="checkbox"/> wheezing
<input type="checkbox"/> sneezing	<input type="checkbox"/> popping	<input type="checkbox"/> watery	<input type="checkbox"/> itchy palate	<input type="checkbox"/> chronic cough
<input type="checkbox"/> itchy	<input type="checkbox"/> congested/ blocked	<input type="checkbox"/> redness	<input type="checkbox"/> itchy throat	<input type="checkbox"/> shortness of breath
<input type="checkbox"/> sniffles	<input type="checkbox"/> none	<input type="checkbox"/> swelling	<input type="checkbox"/> post nasal drip	<input type="checkbox"/> chest tightens
<input type="checkbox"/> nasal discharge		<input type="checkbox"/> dark circles	<input type="checkbox"/> frequent sore throat	<input type="checkbox"/> sputum
<input type="checkbox"/> loss of smell		<input type="checkbox"/> conjunctivitis	<input type="checkbox"/> none	<input type="checkbox"/> none
<input type="checkbox"/> frequent nosebleeds		<input type="checkbox"/> none		
<input type="checkbox"/> none				

How long have you had your symptoms? _____

Are your symptoms (Choose one)

- Perennial: Present all year round but worse at certain times Comments: _____
 Seasonal: Only at certain times of the year e.g. spring Comments: _____
 Coming and going without any relation to time of year Comments: _____

Circle the months when your symptoms are worse:

JAN FEB MAR APR MAY JUN JUL AUG SEP OCT NOV DEC

How long do your symptoms last?

More than 4 days per week Yes No More than 4 weeks in a row Yes No

Are your symptoms worse (circle):

Indoors Outdoors At home At Work At School Mornings Evenings

No Occasionally Frequently Comments

- Do your symptoms restrict your leisure/sport activities? _____
 Do you miss school/work because of your symptoms? _____
 Do your symptoms disturb your sleep? _____

Have you been diagnosed with Asthma? Yes No

What medications you have used to treat your allergy symptoms including nasal sprays:

Type	Oral H1-antihistamine	Nasal H1-antihistamine	Anti-allergic eyedrops	Nasal corticosteroid
Frequency				
Other				

List all other medications you are currently taking:

Past/family history

At what age did you first have an allergic reaction? 0-1yrs 1-5yrs 15-25yrs 25+yrs

What was your first allergic condition (circle):

Hay fever Asthma Eczema Food allergy Insect bite Acute allergic reaction

Is your first allergic condition still your main problem? Yes No

How often did you have colds, sinusitis, upper respiratory infection, hay fever? _____

Have you ever been skin tested or had a blood test for allergies? Yes No

If yes, what year _____ what were the results _____

Has any member of your family had any of the following:

	Mother	Father	Sister(s)	Brother(s)	Grandparents
Asthma					
Hay Fever					

NEW PATIENT ALLERGY QUESTIONNAIRE

Home/work/environment

Do you live in (please circle) house, unit, caravan, farm, other _____ city or country

Is your home air conditioned No Yes if yes (circle) fan ducted/central

Is your home heated (circle) ducted/central, fireplace, gas, electric, other _____

Do you spend much time in air conditioned places home _____ work _____

Your bedroom has (circle) plants, stuffed toys, carpet, rugs, doona, pillows – feather, form or synthetic, drapes, blinds – material or wood, bookshelves, humidifier

Your house (circle) plants, stuffed toys, carpet, rugs, drapes, blinds – material or wood, bookshelves, humidifier, chair coverings – cloth or leather, sofa/lounge – cloth or leather, cushions – feather foam or synthetic

Your workplace (circle) air conditioning, heating, carpet, rugs, blinds – material or wood, chair coverings – cloth or leather, plants

How old is your mattress _____ pillows _____

Do you have the same symptoms when travelling or away from home? Yes No

If no, is there any place/environment where you do not suffer from your symptoms? _____

What pets/animals do you have at home or in the workplace Dog Horse Cat Other _____ None

Do the pets/animals spend time indoors at your home or workplace? Yes No

How long have you had pets? _____

List other pets/animals you are in contact with _____

Doctors use only

SEASONAL PERENNIAL

(Please circle most relevant)

Sleep Y / N

Leisure/Sport activities Y / N

Work/School Y / N

Troublesome symptoms Y / N

Diagnosis:

INTERMITTENT symptoms

- < 4 days per week
- and < 4 weeks

PERSISTENT symptoms

- > 4 days/week
- and > 4 weeks

MILD

- normal sleep
- normal daily activities, sport, leisure
- normal work and school
- no troublesome symptoms

MODERATE-SEVERE one or more items

- abnormal sleep
- impairment of daily activities, sport, leisure
- problems caused at work or school
- troublesome symptoms