

SOUTH TEXAS ENT CONSULTANTS

PATIENT ALLERGY HISTORY QUESTIONNAIRE

Patient Name: \_\_\_\_\_ ENT Physician: McManus/Hatch/McQueen/Guillaume/Noorily

YES/NO Cough? Constant? Intermittent? Daytime? Nighttime?

YES/NO Frequent colds?

YES/NO Temperature/fever with colds?

YES/NO Sneezing?

YES/NO Sore throats? Frequency? \_\_\_\_\_ From infections? YES/NO From drainage? YES/NO

YES/NO Nose drainage? From the nose, or down the throat? Drainage: Clear? Colored? Thick? Thin?

YES/NO Nose blockage/congestion?

YES/NO Eye symptoms? Burning? Puffy? Watery? Itching? Swelling?

YES/NO Headaches? Location \_\_\_\_\_ How often  
\_\_\_\_\_.

YES/NO Fatigue? When?  
\_\_\_\_\_.

YES/NO Shortness of breath? Do you know  
why? \_\_\_\_\_.

YES/NO Asthma? Now? As a Child?

YES/NO Wheezing? Now? As a child? What causes your wheezing? \_\_\_\_\_.

YES/NO Earaches? Do your ears drain? YES/NO Drainage clear or cloudy? Itchy? Stuffy? Flaky? Ring? Buzz?  
Crackle? Pop? Other? Hearing loss?

YES/NO Vertigo? (dizziness)  
When? \_\_\_\_\_.

YES/NO Loss of smell or taste?  
When? \_\_\_\_\_.

YES/NO Laryngitis? When? \_\_\_\_\_.

YES/NO Eczema? Now? As a child? Describe type and  
location \_\_\_\_\_.

YES/NO Hives? When? \_\_\_\_\_ Caused  
by: \_\_\_\_\_.

YES/NO Fungus infections? Athlete's Foot? Vaginitis? Jock Rash?

YES/NO Pets? Inside/Outside? Dog? Breed \_\_\_\_\_ Cat? Other Type of pet? \_\_\_\_\_.

Length of time have had pet? \_\_\_\_\_ Contact that worsens symptoms \_\_\_\_\_.

Symptoms worse when visiting family or friends with pets? YES/NO

YES/NO Do you smoke? If you do not smoke, does someone else smoking bother you? YES/NO.

YES/NO Itchiness? Nose? Roof of mouth? Ears? Hands? Feet? Other?  
\_\_\_\_\_.

YES/NO Do you suspect any food of increasing your symptoms? Specify \_\_\_\_\_.

YES/NO Do you have specific food cravings, or do you overindulge in certain foods?

List:  
\_\_\_\_\_.

YES/NO Does any certain food give you indigestion, hives, or otherwise bother/upset you?

List: \_\_\_\_\_

YES/NO Do you awaken in the morning with any symptoms? Joint pain/stiffness? Increased congestion?

Increased drainage? Nausea? Other? \_\_\_\_\_

**Do your symptoms increase, decrease or stay the same with the following conditions?**

Weather Changes: Warm / Cold / Windy / Rainy? \_\_\_\_\_

Season Changes: Spring / Summer / Fall / Winter? Certain months? \_\_\_\_\_

Exposure to dust? \_\_\_\_\_ High pollution levels? \_\_\_\_\_ Mowing grass \_\_\_\_\_

When the air conditioner or furnace goes on? \_\_\_\_\_

Going to bed / After asleep for a short time / In the morning / In the afternoon? \_\_\_\_\_

**Home, work, and vacation environment**

What is your occupation? \_\_\_\_\_

Do you participate in any particular activities, hobbies, or recreation? Specify \_\_\_\_\_

Are your symptoms increased at HOME/WORK/NO CHANGE?

Are you exposed to excessive amounts of Dust? Fumes? Chemicals? Noise? Specify \_\_\_\_\_

When on vacation do your symptoms Improve? Get Worse? Stay the same?

Where do you usually go on vacation? Mountains? Seashore? Big City? Specify \_\_\_\_\_

**Housing**

Do you live in a House? Apartment? Trailer/Mobile Home? Other? \_\_\_\_\_

How old is the building (house, trailer, or apartment) you are living in? \_\_\_\_\_

Do you have heating and air conditioning? Is it Central / Window unit.

**Allergy History**

How long have you had specific symptoms that brought you to our office? Years? Months? Weeks? Days?

Have you ever had allergy testing done before?

Name of the doctor who performed the testing? \_\_\_\_\_ Date of last testing \_\_\_\_\_

Were there any positive reactions? YES/NO To what? \_\_\_\_\_

Were you treated with Medication / Allergy shots / Surgery? For how long? \_\_\_\_\_

Did your symptoms improve? YES/NO

PLEASE LIST **ALL** MEDICATIONS YOU ARE CURRENTLY TAKING:

Do you have any allergies to medications? Please list and give reaction to each medication.

Is there something in particular you feel or know you are allergic to such as: trees/weeds/grasses/dogs/cats/dust mites or foods? If so please list below.