SPRING VALLEY ALLERGY QUESTIONNAIRE

Please fill out the questions below to the best of your ability prior to your upcoming visit. The information you provide will help the Allergy Team provide the best care possible.

DEMOGRAPHICS

Patient Name: Patient DOB:

Gender: Cell Phone:

Parent 1 Name (if applicable):

Parent 2 Name (if applicable):

Street:

City: State: Zip Code:

Work Phone: Email:

Patient or Parent Employer(s):

Referred by:

Primary Care Physician:

Pharmacy of Choice:

TODAY'S VISIT

Reason for your visit today:

What season(s) do your symptoms occur (please list all):

What triggers your symptoms (pollen, animals, mold, dust, pollution, weather and season changes, foods, other):

Are symptoms worse day, night, or both:

Are symptoms worse at home and/or outside the home:

Any other relevant details:

ALLERGY AND ASTHMA HISTORY

Asthma	Yes ○	No ○
Have you ever been hospitalized for asthma?	Yes ○	No ○
Seasonal or indoor allergies	Yes ○	No ○
Food allergies	Yes ○	No ○
Eczema	Yes ○	No ○
Medication allergies	Yes ○	No ○
Skin contact allergies	Yes ○	No ○

MEDICAL HISTORY

List any chronic medical conditions and age of diagnoses:

Any hospitalizations in the past? When and for what condition?

Have you ever had allergy testing before? Which method? When? Results?

Have you been on allergy shots before? When? How long?

SURGICAL HISTORY

List any past and planned future surgeries and respective dates:

FAMILY HISTORY

(List below any first-degree family members with environmental allergies, asthma, eczema, food allergies, drug allergies, insect sting allergies, contact dermatitis, hives, angioedema/swelling, immune deficiency diseases, or any other chronic medical conditions. Please specify which family members have which conditions below)

Family Member	Diagnoses

CURRENT ENVIRONMENT

Animals in the home (type of animal(s), age(s), and areas of home allowed)

Type of home

Type of floors in the home

Type of heating and A/C

Any problems with mold, damage, or renovations in the home

Smokers in the household

Personal smoking history (if relevant)

Occupation (if relevant)

Grade and name of school

What city do you live in now?

What cities have you lived in before?

CURRENT MEDICATIONS

Name	Dose	Frequency

REVIEW OF SYMPTOMS - CONTINUES ON NEXT PAGE

On the following pages, select Yes or No for each symptom and use the comment field for the nature of the problem or approximate date, as applicable.

REVIEW OF SYMPTOMS

Please indicate by checking "yes" or "no" if you have had any significant problems in the areas below.

Yes	No	Nature of problem	Comment / approximate date
○	○	Recent weight loss or gain	
○	○	Headaches	
○	○	Vision or hearing trouble	
○	○	Thyroid problems	
○	○	Diabetes	
○	○	Anemia or abnormal bleeding	
○	○	High or low blood pressure	
○	○	Recurrent sinus or ear infections	
○	○	Recurrent pneumonias	
○	○	Chest pain	

REVIEW OF SYMPTOMS

Please indicate by checking "yes" or "no" if you have had any significant problems in the areas below.

Yes	No	Nature of problem	Comment / approximate date
○	○	Shortness of breath, cough, wheezing, chest tightness	
○	○	Liver, gallbladder disease, jaundice	
○	○	Stomach (ulcer, indigestion, constipation, diarrhea, change in bowel movements)	
○	○	Abdominal pain	
○	○	Urinary/kidney/bladder problems	
○	○	Joint pain or stiffness	
○	○	Depression/anxiety	
○	○	Fainting	
○	○	Strokes or seizures	
○	○	Pain in other areas	
○	○	Skin rashes	
○	○	Other	