NEW PATIENT ALLERGY QUESTIONNAIRE

Name ______________________ Age ______________________ Sex ☐ M ☐ F

Occupation ____ Date ______________________

Current history

Symptoms (please tick)

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

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

Diagnosis:

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