South Island Allergy Service

Allergy Clinic Questionnaire

Date:	Name:	Date of Birth:
Occupation:	Ethnicity:	Phone:
Email:		NHI (if known):
Address:		

List your main symptoms or complaints (and duration):

A:

B:

C:

D:

Write down medications you are taking (incl. non-prescription medications, alternative medications, creams, inhalers, sprays). Include trade and generic names, their strength and how often you take them:

Medication:	**Strength/frequency:**

Please circle yes or no and add any additional comments below:

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

Have you had an anaphylactic reaction before? YES NO
(Sudden severe collapse/shock after food, drugs, or any cause)

What was the cause of this? _____

Do you suffer from asthma? YES NO

Do you suffer from eczema? YES NO

Do you suffer from hives? (Urticaria) YES NO

Do you suffer from hay fever? YES NO

Do you suffer from sinus troubles? YES NO

Do you suffer from frequent colds? YES NO

Do you suffer from persistent cough? YES NO

Do you suffer from diarrhoea? YES NO

Do you suffer from abdominal cramps? YES NO

Have you had an sinus surgery? YES NO

Is your condition seasonal? YES NO

If yes, which season is worse? _____

How often do you have attacks? _____ How long do they last? _____

Comments:

Contact Allergy

Have you ever had a skin reaction to jewellery? YES NO

Have you ever had a patch test? YES NO

Have you ever had a skin reaction to skincare products or cosmetics? YES NO

Childhood Allergy History

Did you have asthma? YES NO

Did you have runny nose (Rhinitis)/hay fever? YES NO

Did you have eczema? YES NO

Did you have vomiting, diarrhoea, colic? YES NO

Family History

Has any of your first degree relatives (parents or siblings) had:

Asthma YES NO Relationship:

Eczema YES NO Relationship:

Rhinitis (hay fever) YES NO Relationship:

Please write down any family history, particularly of allergy, autoimmune problems or immunology (for example recurrent infections). If possible, please specify which particular relatives suffered from these problems and if they were from your mother's or father's side:

Food History

Do you suspect any foods are causing allergy symptoms? YES NO

If yes, which foods and what symptoms are associated with these foods?

Are you omitting any food/s at present? YES NO

If yes, which foods?

Environmental History

Do you have a cat? YES NO Do you have a dog? YES NO

Are you symptoms better on holidays? YES NO Are you worse at work? YES NO

Are you symptoms brought on or worsened by exercise? YES NO

Please write down your hobbies/interests:

Comments:

Drug/Medication History

Are you sensitive/allergic to any drugs? YES NO

If Yes, please list the drug(s) and what reaction you had:	
Drug	**Reaction**

General Medical History

Do you have high blood pressure? YES NO

Are you pregnant? YES NO

Do you have diabetes? YES NO

Do you smoke? YES NO

If Yes, for how many years have you smoked, and how many cigarettes per day?

Would you like your consult letters to be sent to your general practice? YES NO
If Yes, please provide the name of your general practice _____

Is there any other information you would like to share that would be useful?

PLEASE EMAIL THIS COMPLETED FORM TO US BEFORE YOUR APPOINTMENT.
IF THERE ARE ANY ADDITIONAL DOCUMENTS YOU WOULD LIKE TO SEND TO US THAT MAY ASSIST WITH THE CONSULTATION PLEASE DO SO.