ALLERGY RELIEF QUESTIONARE

Name: ____ **Date:** ___________________

Address: ____ **Date of Birth:** ________________________

City, State, Zip: _____________________________________ **Home#:** (_____)_______________________

Gender (circle one): **MALE** **FEMALE** **Work#:** (_____)_______________________

Primary Care Physician: ______________________________ **Cell #:** (_____)_______________________

Email Address: ____

(Kept strictly confidential for our communication to you only-your email address will never be shared with anyone else)

How did you hear about our office? ☐ I am a current patient ☐ Friend/Family ☐ Physician ☐ Sign ☐ Newspaper ☐ Internet banner ad ☐ Google search ☐ Yahoo search ☐ Radio/TV ☐ Other ______________________________

Although your history and symptoms are very important in our analysis of your condition, it is also important for us that you understand:

- *We do not treat symptoms or diseases.*
- *Allergy is not a disease, rather a condition.*
- *A symptom is an attempt by your body to tell you something.*
- *We will attempt to find the underlying cause.*
- *We do not use drugs in this program.*
- *There is no single "healthy" diet that will work for everyone.*
- *Just because food is considered "healthy", does not mean it is "healthy" for you.*
- *Your diet consists of everything you* ***eat, drink, rub on your skin, or inhale****.*
- *Our procedures are safe and painless.*

Briefly describe the reason for your visit and what you hope to accomplish: ______________________________

____

AGE WHEN SYMPTOMS WERE FIRST OBSERVED

☐ ☐Infant (Age 0-2) ☐ ☐Child (Age 3-5)
☐ ☐Child (Age 6-12) ☐ ☐Adolescent (Age 13-18)
☐ ☐Adult (Age 19-25) ☐ ☐Adult (Age 26-40)
☐ ☐Adult (Age 41 and over)

DID YOU SUFFER FROM ANY TYPE OF PHYSICAL, CHEMICAL OR EMOTIONAL TRAUMA JUST BEFORE YOUR SYMPTOMS WERE FIRST OBSERVED? ______________________________

HAVE YOUR SYSMPTOMS EVER GONE AWAY FOR ANY PERIOD OF TIME? ________________________

Check any of the substances you believe may be causing you to have a negative reaction:

____Meats
____Shell Fish
____Vegetables
____Food Components
____Dairy
____Coffee
____Eggs
____Fabrics or Upholstery
____Detergents, Softeners
____Chocolate
____Nutritional Supplements
____Herbal Remedies
____Sugars
____Red or White Wine
____Beer
____Berries
____Metals
____Dust & Dust Mites
____Animal Dander
____Plastics
____Stinging Insects
____Environmental
____Sunlight
____Woods, Metals
____Fruit
____Yeast
____Molds
____Airborne Irritants
____Trees
____Grasses, Weeds
____Nightshade foods
____Grains
____Chemicals
____Perfumes
____Latex
____Other______________________

Please answer the following about the above allergens:

Which of the above irritants are the worst? ____

On a scale of 1 to 10, how would you rate your discomfort? ___________ [1 = minimal / 10 = severe]

How long have you been suffering with your allergy condition(s)? ____

How are these conditions affecting your ability to perform daily tasks? ______________________________________

____

Would you like to eliminate or reduce these problems? ☐ Yes ☐ No

On a scale of 1 to 10, how would you rate your motivation to eliminate or reduce these problems? ______(1=low /10=high

PREVIOUS DIAGNOSIS OF ALLERGY

☐ Yes and allergy shots helped
☐ Yes but allergy shots did not help
☐ Yes and medication helped
☐ Yes but medication did not help
☐ None

FAMILY MEMBERS WITH ALLERGIC SYMPTOMS

☐ Mother
☐ Father
☐ Brother/Sister
☐ Grandparents
☐ Son/Daughter
☐ Spouse
☐ None

FREQUENCY & SEVERITY OF ALLERGY SYMPTOMS

☐ Constant/Chronic with little change
☐ Present most of the time
☐ Present part of the time
☐ Present rarely

☐ Prevents some normal activities
☐ Considerable interference with normal life
☐ Slight interference with normal life
☐ No interference with normal life

SYMPTOMS ARE WORSE

- ☐ Outdoors and better indoors
- ☐ In the bedroom or when in bed
- ☐ During wet or damp weather
- ☐ During known pollen seasons
- ☐ When exposed to tobacco smoke
- ☐ When sweeping or dusting the house
- ☐ In air conditioning
- ☐ At nighttime
- ☐ During windy weather
- ☐ When the weather changes
- ☐ In certain rooms or buildings
- ☐ With yard work, cut grass, leaves, hay or barns
- ☐ In areas with mold or mildew
- ☐ In fields or in the country
- ☐ Tobacco smoke bothers me more than anything else

SYMPTOMS ARE BETTER

- ☐ After shower or bath
- ☐ Indoors
- ☐ After taking antihistamines
- ☐ In air conditioning
- ☐ During or after physical activity
- ☐ With allergy shots

What makes you feel better? ____

____

ANIMALS, INSECTS AND BIRDS THAT CAUSE SYMPTOMS ON EXPOSURE

- ☐ Dogs
- ☐ Cats
- ☐ Rodents (mice, guinea pigs, etc.)
- ☐ Horses or Cattle
- ☐ Rabbits
- ☐ Birds or Feathers
- ☐ Bees
- ☐ Other ____
- ☐ None

FOOD RELATED SYMPTOMS

- ☐ Symptoms flare 5-60 minutes after meals
- ☐ The smell or odor of some foods increases symptoms
- ☐ Some foods cause swelling of the mouth or tongue
- ☐ Some foods cause upset stomach or vomiting
- ☐ Symptoms occur with restaurant salad bars or Asian foods
- ☐ Symptoms occur with any regularly eaten food
- ☐ Preservatives, additives or food coloring increase symptoms
- ☐ Some foods are craved or addictive
- ☐ Some foods cause nasal symptoms
- ☐ Some foods cause rashes or hives
- ☐ Some foods cause diarrhea
- ☐ Some foods cause headaches
- ☐ Some foods cause asthma
- ☐ No problem with foods

FOODS THAT CAUSE SYMPTOMS FROM <u>ONE HOUR TO THREE DAYS</u> AFTER EXPOSURE

- ☐ Eggs
- ☐ Milk
- ☐ Beef
- ☐ Corn
- ☐ Wheat
- ☐ Soybean
- ☐ Peanut
- ☐ Pork
- ☐ Fish
- ☐ Shellfish
- ☐ Orange or other citrus
- ☐ Potato
- ☐ Tomato
- ☐ Yeast
- ☐ Chocolate
- ☐ Coffee or Tea
- ☐ None
- ☐ Other ______________________________

CHEMICALS THAT CAUSE SYMPTOMS

- ☐ Insecticides & pesticides
- ☐ Perfumes & cosmetics
- ☐ Stove or furnace emissions
- ☐ Chemicals in the workplace
- ☐ Newsprint
- ☐ None
- ☐ Paints & household cleaners
- ☐ Gasoline or automobiles exhaust
- ☐ The smell of new fabrics or fabric store
- ☐ Laundry detergent
- ☐ Other: ____

WHEN ARE YOUR SYMPTOMS WORSE

☐ Year around

☐ January	☐ February	☐ March	☐ April
☐ May	☐ June	☐ July	☐ August
☐ September	☐ October	☐ November	☐ December

MEDICATIONS

Do you take any of the following medications on a regular basis?

- ☐ Antihistamines (Benadryl, Actifed, Chlortrimeton, Tylenol Sinus, Tylenol Sleep, Dimetapp,Drixoral, Trimalin, Atarax, Claritin, Allegra, Zyrtec, etc)
- ☐ Bronchodilators (Albuterol, Ventolin, Proventil, Serevent, or OTS's such as Primatine Mist, etc)
- ☐ Steroid Inhalers (Asmacort, Flovent, Pulmicort, Beclovent, Aerobid, Advair, etc)
- ☐ Nasal Steroids (Beconase, Flonase, Nasacort, Rhinocort, etc)
- ☐ Medications that affect the immune system (Prednisone, Imuran, Methotrexate, Cellcept, Cyclosporine, Tacrolimus, etc)
- ☐ Chemotherapy

Please list any medications that you are currently taking: ____

____

SMOKING

Do you presently smoke? ☐ Yes ☐ No If yes, average number of cigarettes per day ___________

If yes, at what age did you start? ____

Does anyone smoke in your home? ☐ Yes ☐ No

PREVIOUS ALLERGY EVALUTION

Have you ever seen an allergist? ☐ Yes ☐ No

Have you had allergy skin testing? ☐ Yes ☐ No

Did you have any positive reaction? ☐ Yes ☐ No

If yes, please list positive allergens (include any medications) ____

Have you ever received allergy injections? ☐ Yes ☐ No

Have you ever received cortisol (prednisone etc.) drugs? ☐ Yes ☐ No If yes, when _________ How often?_________

WORK ENVIRONMENT

What is your occupation? ____

Are you exposed to chemicals or strong odors at work? ☐ Yes ☐ No Are you symptoms worse while at work?

If yes, briefly explain ____

ANY ADDITIONAL INFORMATION YOU WOULD LIKE US TO KNOW? ______________________________

____

____

____

____

____

ANYTHING ELSE YOU WOULD LIKE TO ASK? ______________________________________

____

____

____

____

____

____ ____________________

Patients Signature **Date**