ALLERGY and ASTHMA CENTER of AUSTIN

William C. Howland III, M.D. ALLERGY QUESTIONNAIRE

INSTRUCTIONS: Please answer the questions on this form as they relate to the person being evaluated. Please bring the completed forms to our office for your first appointment.

Patient's Name:_____Sex:_____Age:_____Date of Birth:_____

Referred by:_____Primary Doctor:_____Appointment Date:_____

I. BRIEFLY DESCRIBE the reason for your allergy visit and what you hope to accomplish:_____

_____

_____

II. SYMPTOMS: Do you experience any of the following? (Check ✔ each box that applies to you.)

✔	NOSE:	✔	SINUS:	✔	CHEST:	✔	SKIN:
	Stuffy nose		Headaches		Tightness		Rash
	Sneezing		Sore throats		Wheezing		Hives
	Itching		Post nasal drainage		Wheezing when exposed to		Eczema
	Clear / colorless discharge		Throat clearing / sniffing		dust, pollen, animals, etc.		Swelling
	Thick / colored discharge		Hoarseness		Wheezing with colds / infections		Itching
	Mouth breathing / snoring		Bad breath		Wheezing/cough after exercise		Sores
	Loss or decreased sense of smell		Frequent infections		Shortness of breath	✔	**OTHER:**
	Nose bleeds	✔	**EAR:**		Productive cough		Fatigue
✔	**EYE:**		Itching		Dry cough		
	Red		Full / popping		Bronchitis		
	Itchy		Painful				
	Watery		Ringing / hearing loss				
	Dark circles / puffiness		Frequent infections				

III. TRIGGERS OF YOUR SYMPTOMS: Are your symptoms ❑ Year Round ❑ Seasonal ❑ Both?

During what months do you usually have symptoms? ❑ January ❑ February ❑ March ❑ April ❑ May ❑ June ❑ July ❑ August ❑ September ❑ October ❑ November ❑ December

Which of the following cause your symptoms or make them worse? (Check ✔ each box that applies to you.)

	Mowing lawn / yard work		Weather change		Perfume		Morning
	Vacuuming / house dust		Wet weather		Chemical fumes		Afternoon
	Cedar		Dry weather		Smoke		Night
	Pollen		Windy day		Cleaning agents		Alcohol
	Mold or mildew		Hot day		Newspaper		Beer
	Damp areas		Cold day		Indoors		Wine
	Dogs		Air-conditioning		Outdoors		Stress
	Cats		Air pollution		At home		Other
	Other animals				At work		

✍ ✍ ✍ **DO NOT WRITE BELOW THIS LINE** ✍ ✍ ✍

Clinical Summary:_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

IV. DURATION / SEVERITY OF SYMPTOMS:

Have your symptoms been present: ☐all of your life? ☐_____month / years? Are your symptoms:

	Mild		Rare		Interfering with your life
	Moderate		Frequent		Preventing many normal activities
	Severe		Constant		

V. FOOD REACTIONS: Have you ever had any ***systemic symptoms*** (itching, hives, wheezing, shortness of breath, throat swelling, dizziness, fainting, shock) after ingestion of food or liquid? ☐YES ☐NO If yes, specify:

_____

_____

MEDICATIONS:

Please list ALL PRESENT medication below ⬇	Dose	Date Started	List PREVIOUS ALLERGY and/or ASTHMA medications below ⬇
1			
2			
3			
4			
5			
6			
7			
8			

Have you used nasal sprays? ☐YES ☐NO If yes, name:_____
Have you taken cortisone (steroids) ? ☐YES ☐NO If yes, when_____

MEDICATION REACTIONS: List any medication allergy or reaction below.

Medication	Approximate Date	Symptoms

PAST MEDICAL HISTORY:

⬇Please list any surgeries / hospitalizations / medical conditions below ⬇	Date

SMOKING: Do you presently smoke? ☐YES ☐NO If yes, average number of cigarettes per day _____
If yes, when did you start? _____