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:_________

Welcome to our office! Please complete this questionnaire to help your transition from Dr. Harden's care.

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 dust, pollen, animals, etc.		Eczema
	Clear/ Colorless discharge		Throat Clearing/ Sniffing		Wheezing/ Cough after exercise		Swelling
	Thick/ Colored Discharge		Hoarseness		Wheezing with Colds/ Infections		Itching
	Mouth breathing/ Snoring		Bad Breath		Productive Cough		Sores
	Loss or Decreased Sense of Smell		Frequent Infection		Dry Cough	☑	**OTHER:**
	Nose Bleeds	☑	**EAR:**		Bronchitis		Fatigue
☑	**EYE:**		Itching		Shortness of Breath		
	Red		Full/ Popping				
	Itchy		Painful				
	Watery		Ringing/ Hearing Loss				
	Dark Circles		Frequent Infection				

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 Changes		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		News Paper		Beer
	Damp Areas		Cold Day		Indoors		Wine
	Dog		Air-Conditioning		Outdoors		Stress
	Cats		Air Pollution		At Home		Other
	Other Animals				At Work		

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

Clinical Summary: ____

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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		

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:

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MEDICATIONS:

Please list **All Present** medications 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

Do you have any Pets? ☐ YES ☐ NO If yes, List number and kind (i.e. dog, cat, bird, etc.)

Are your allergy / asthma symptoms worse around your pets? ☐ YES ☐ NO

Do your pets live: ☐ Indoors ☐ Outdoors ☐Both?

SOCIAL HISTORY:

When did you move to Central Texas? _____ Are you: Married Single Widowed Divorced Significant Other

What was the last grade you completed? ____

How many children do you have?_______________ Their ages:___________________

Do you exercise? ☐ YES ☐ NO If yes, How often?_______________ How long?__________

Do you drink alcohol ☐ YES ☐ NO If yes, how often?____________ How Much?_________

SMOKING:

Do you presently Smoke? ☐ YES ☐ NO If yes, average number of cigarettes per day: ___________________

If yes, when did you start? ____

Have you ever smoked? ☐ YES ☐ NO If yes, how many years? ___________ When did you stop? _________

Average number of Cigarettes you smoke per day? _________________________

Does anyone smoke in your home? If yes, Who? _____________________________

WORK:

What is your occupation? ____________________ Where are you employed? ___________________

How long have you worked there?_________ Is your work environment: Carpeted Tiled Other

Have you missed time from school or work because of your allergies / asthma? ☐ YES ☐ NO

SYSTEMS REVIEW: Do you have recurring or chronic problems with any of the following?

	Frequent headaches		Chest pain		Heartburn
	Vision disturbance		Pneumonia		Constipation
	Wear glasses		High blood pressure		Diarrhea
	Wear contacts/ soft/ gas perm		Rapid Heart beat		Frequent / painful urination
	Frequent cold, ____per year		Nausea / vomiting		Arthritis

Any other chronic symptoms? ____

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What is your weight now? ________________What was your weight one year ago?_________________________

When was your last chest X-Ray? ______________ Results: ____

Have you had sinus X-Rays? ☐ YES ☐ NO If yes, Results: ____

ALLERGY INJECTIONS:

Are you presently taking allergy shots? ☐ YES ☐ NO

How often do you receive injections? ___________________________

Have you had any reactions to allergy injections? ☐ YES ☐ NO If yes, Please describe_____________________

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