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SLEEP AND SINUS INSTITUTE

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Allergy Questionnaire

Name:_______________________________________Date of Birth: _________________

Do you have a history of?

1. Asthma? [ ] Yes [ ] No
   a. How often do you use your rescue inhaler?_____________________________
   b. Have you ever been hospitalized for a severe asthma attack? [ ] Yes [ ] No
2. Repeated sinus infections? [ ] Yes [ ] No
3. Multiple colds per year? [ ] Yes [ ] No If so, how many? _____________________
4. Repeated ear infections? [ ] Yes [ ] No
5. Severe allergic reaction or anaphylaxis (shock)? [ ] Yes [ ] No
6. Being hospitalized for an allergic reaction? [ ] Yes [ ] No
7. Prior allergy testing? [ ] Yes [ ] No
8. Smoking? [ ] Yes [ ] No If yes, how much?_________How long?_________
9. Second-hand smoke exposure? [ ] Yes [ ] No How often?______________

1. Do you take Beta Blockers? [ ] Yes [ ] No
2. Do you take MAO-Inhibitors? [ ] Yes [ ] No

General Symptoms: Check line beside symptoms that best describe your allergies

Pollen Allergy Symptoms	Dust Allergy Symptoms	Mold Allergy Symptoms
[ ] Worse outdoors	[ ] Worse indoors	[ ] Worse outdoors from 4 to 9pm
[ ] Better indoors	[ ] Better outdoors	[ ] Worse in low, damp places
[ ] Worse on clear days	[ ] Worse in cold weather	[ ] Worse on windy days
[ ] Worse in warm or cool air	[ ] Worse when sleeping	[ ] Worse on cool evenings
[ ] Worse in change of temp	[ ] Worse when dusting	[ ] Worse mowing/ playing in grass
[ ] Worse on windy days	[ ] Worse 30 min. after retiring	
[ ] Worse outdoors 7 to 11 am		

1. Are your allergy symptoms: [ ] ALL THE TIME or [ ] SOMETIMES
2. What medicines have helped your allergy symptoms? _______________________
3. During what months do you usually have allergy symptoms? _________________
4. During what months are your allergy symptoms most severe? _________________

Check all that Apply

Does your nose feel?

	Never	Sometimes	Seasonally	Constantly
Stuffy				
Runny				
Itchy				
Post-Nasal Drip				

Do your eyes feel?

	Never	Sometimes	Seasonally	Constantly
Full/Plugged up				
Itchy				
Sore/Painful				
Wet/Discharge				

Do you sneeze frequently?

	Never	Sometimes	Seasonally	Constantly
Year Round				
Seasonally				
Daytime				
Nighttime				

Do you cough frequently?

	Never	Sometimes	Seasonally	Constantly
Year round				
Seasonally				
Daytime				
Nightime				

1. Do you have any dogs? [ ] Yes [ ] No [ ] Indoor or [ ] Outdoor?
2. Do you have any cats? [ ] Yes [ ] No [ ] Indoor or [ ] Outdoor?
3. Do you have birds? [ ] Yes [ ] No
4. Do you have houseplants? [ ] Yes [ ] No
5. Do you have feather pillows? [ ] Yes [ ] No
6. Do you have a down comforter? [ ] Yes [ ] No
7. What type of housing do you have? [ ] House [ ] Duplex [ ] Apartment [ ] Condo [ ] Other
8. When was it built?________________
9. Where do you live? [ ] City [ ] Suburban [ ] Rural [ ] Farm
10. Do you have any food allergies? [ ] Yes [ ] No Specify: __________________________
11. Is there a family history of allergies? [ ] Yes [ ] No