Allergy Testing Questionnaire

Patient Name: **DOB:**

Allergy Symptoms: ***Eyes:*** □ itchy □ watery □ swollen
Ears: □ itching □ draining □ congested □ pain
Nose: □ runny □ congested □ post nasal drip
Head: □ headaches □ allergy related
Cough: □ yes □ no □ productive
Sneezing: □yes □ no
Other: ______________________________

When do you notice allergy symptoms? □ Seasonal □ Perennial □ Both

Do you have asthma? □ yes □ no
How long? ______________________________
What medications do you take for asthma? ______________________________
Have you been to the ER for Asthma? □yes □no

Do you have food sensitivities? □ yes □ no

Other allergy triggers: ______________________________

Have you had allergy testing in the past? □ yes □ no
Type of testing: ______________________________
Tolerated well? □ yes □ no
Explain any reactions: ______________________________

Have you had previous allergy injections? □ yes □ no
Tolerated well? □ yes □ no

How long have you lived in the area? ____________ **Where did you move from?** ______________________________
Are your symptoms worse since moving? □ yes □ no

Do you own pets? □ yes □ no **Type:** ______________________________
Are they indoor pets? □ yes □ no
Allowed in the bedroom? □ yes □ no
Allowed on the bed? □ yes □ no
Symptoms present around cats or dogs? □ yes □ no

Ok to test both arms? □ yes □ no

Any possibility of pregnancy? □ yes □ no

Comments: ______________________________
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