Allergy Testing Questionnaire

<table>
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<th>Patient Name:</th>
<th>DOB:</th>
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**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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