CONNECTICUT, EAR, NOSE & THROAT, SINUS & ALLERGY SPECIALISTS, P.C.
ALLERGY DEPARTMENT

ALLERGY HISTORY QUESTIONNAIRE

Name: _____ Date: _____

Are you pregnant? Yes No

Have you ever been tested for allergies: Yes No

Where? _____ How long ago? _____

Were you found to be allergic? Yes No To what? _____

Were you treated with allergy shots? Yes No For how long? _____

Did the treatment help? Yes No Somewhat

Please list all daily medications; include eye drops, vitamins, etc. _____

_____

Have you ever had a bad reaction to any medication? Yes No

If yes, list medication(s) and describe the reaction _____

_____

Do you have any health problems? Please list _____

Are you often sick? Yes No Describe _____

Do you have pets? Yes No What kind? _____

Are you exposed to animals other than in your home? Yes No
Where? Work? Other families' homes? Friends' Homes?

Do you use any of the following in your home: humidifier Yes No
air purifier Yes No
air conditioner Yes No

Do you participate in hobbies or sports? _____

If so, what type? _____

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Do you have any of the symptoms listed below? Please circle all that apply.

Cough	Yes	No	Constant Intermittent Daytime Nighttime
Itchiness	Yes	No	Roof of mouth Nose Throat Hands Ears Eyes
Sneezing	Yes	No	At a particular time? _____
Sore Throat	Yes	No	When is it worse? AM or PM
Nasal Drainage	Yes	No	Clear Cloudy Yellow Green
Eye Symptoms	Yes	No	Burning Watery Puffy Dark circles underneath
Wheezing	Yes	No	With exercise In cold weather At rest
Headache	Yes	No	Frequency? _____ Part of the head/face _____
Asthma	Yes	No	Since when? _____ Is it under control? Yes No
Ear Problems	Yes	No	Stuffy Drainage Infections Ringing Hearing loss
Frequent Colds	Yes	No	How frequent? _____
Hives	Yes	No	What causes them? _____
Eczema/Skin rash	Yes	No	Now As a child
When are your symptoms worse?			Spring Summer Fall Winter