KAISER PERMANENTE®

The Permanente Medical Group, Inc.
Redwood City

ALLERGY QUESTIONNAIRE

MY PREFERRED NAME IS	AGE	VISIT DATE	MR #

My main allergy concern is: ____________________

At this visit I hope to have: ☐ Testing ☐ Opinion ☐ Treatment recommendations ☐ Other

Please check your symptoms and complaints, then circle the most bothersome ones:

CHEST	NOSE	EYES	THROAT	SKIN	REACTIONS	OTHER
☐ Asthma	☐ Itchy	☐ Itchy	☐ Itchy	☐ Itchy	☐ Drug	☐ Headache
☐ Wheezing	☐ Congested	☐ Watery	☐ Post nasal drip	☐ Rash	☐ Food	☐ Heartburn
☐ Tight, congested	☐ Runny nose	☐ Swollen	☐ Soreness	☐ Welts/hives	☐ Bees	☐ Snoring
☐ Shortness of breath	☐ Sneezing	☐ Red	☐ Hoarse voice	☐ Eczema	☐ Latex	☐ Poor quality sleep
☐ Chest cough	☐ Loss of smell	**EARS**	☐ Throat clearing	☐ ________	☐ ________	☐ Fatigue
☐ Chest colds	☐ Polyps	☐ Itchy	☐ Swelling		☐ ________	☐ Depression
	☐ Bleeding	☐ Blocked			☐ ________	☐ Anxiety

When are these symptoms present? ☐ Year-round? **When are they worse?** ☐ Winter ☐ Spring ☐ Summer ☐ Fall

How long have you had symptoms? ____________________

Check any of the following that make symptoms worse:

☐ Animals ☐ House dust ☐ Temperature changes ☐ Aspirin/ibuprofen ☐ Indoors ☐ Outdoors
☐ Pollens ☐ Strong odors / tobacco smoke ☐ Foods: ____________________

Do any of your symptoms limit your ability to (do):

☐ Sports/exercise ☐ Walking ☐ Housework ☐ Work ☐ Sleep ☐ Relax
☐ How else do your symptoms affect your life? ____________________

Occupations, current and past: ____________________

WORKPLACE EXPOSURES (please check off any of the following exposures at work):

☐ Solvents, spray painting ☐ Exhaust fumes ☐ Strong odors including perfumes ☐ Smoke
☐ Birds, pigeons, poultry ☐ Mold ☐ Other: ____________________

Does your current work seem to affect your allergy? ☐ No ☐ Yes: ____________________

HOME ENVIRONMENT (please check if you have any of these items in your home):

ANIMALS	PILLOW	MATTRESS	FLOORING	MOLD	HEATING
☐ None	☐ Feather	☐ Regular	☐ Wall to wall carpeting	☐ Bedroom wall	☐ Central heat
☐ Cat	☐ Synthetic	☐ Feather bed	☐ Area rug	☐ Closets	☐ Wall/space heater
☐ Dog		☐ Water bed	☐ Wood	☐ Bathroom	☐ Fireplace
☐ Bird		☐ Foam rubber or pad		☐ Basement	
☐ Other ________	**BLANKET**	**OTHERS**	**WINDOWS**	☐ Compost	**SMOKE**
☐ Multiple stuffed animals	☐ Down	☐ Multiple plants	☐ Curtains/drapes	☐ Other ________	☐ Tobacco
	☐ Wool	☐ Knick knacks	☐ Blinds/shades		☐ Other
	☐ Synthetic	☐ Bookshelves			

TOBACCO HISTORY:

☐ Currently smoking ☐ Total years smoked: ________ ☐ Average packs/day: ________
☐ Years of second hand smoke exposure: ________ ☐ Quit, when: ________ ☐ Never smoked

BEE STING ALLERGY:

Are you allergic to bees, yellow jackets, hornets, or wasps? ☐ No ☐ Never been stung ☐ Yes

Details: ____________________

Please turn over and continue on other side

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FOOD ALLERGIES (please check symptoms and indicate foods that may cause them):

SYMPTOMS	FOODS THAT CAUSE THIS REACTION
☐ Difficulty swallowing ☐ Difficulty breathing	
☐ Itching of mouth or throat	
☐ Hives ☐ Swelling ☐ Eczema ☐ Other rash	
☐ Cramping ☐ Nausea/vomiting ☐ Gas ☐ Diarrhea	
☐ List other:	

DRUG ALLERGIES:

DRUG	REACTION	APPROX DATE

FAMILY HISTORY:

RELATIVE	Nasal Allergy	Asthma	Eczema	Hives/ Swelling	Food Allergy
Father					
Mother					
Brothers					
Sisters					
Sons					
Daughters					

CURRENT MEDICATIONS (include prescription and over-the-counter medications, e.g., birth control, aspirin, supplements, vitamins, minerals, herbs, etc.):

CHRONIC MEDICAL PROBLEMS:

☐ Glaucoma or cataracts
☐ Broken nose
☐ Nose/sinus surgery
☐ Recurrent sinusitis
☐ Sleep apnea
☐ High blood pressure
☐ Heart condition
☐ Diabetes
☐ Emphysema/COPD
☐ Chronic bronchitis
☐ Acid reflux
☐ Irritable bowel
☐ Thyroid disease
☐ Positive TB tests
☐ Skin condition, specify:
☐ Cancer or tumors
☐ HIV/AIDS
☐ Immune deficiency
☐ Osteoporosis
☐ Hepatitis/liver disease
☐ Other serious conditions: ______________________ ______________________

PAST MEDICAL HISTORY:

Previous allergy treatment: ☐ Shots ☐ Allergy test results: ______________________

Have you ever used steroid/cortisone drugs? ☐ No ☐ Yes: ______________________

Have you ever been to the ER for asthma? ☐ No ☐ Yes: ______________________

RELEVANT HOSPITALIZATIONS (include asthma, and ears, nose, sinus, or lung surgeries):

YEAR	REASON FOR HOSPITALIZATION	YEAR	REASON FOR HOSPITALIZATION

SOCIAL HISTORY:

If patient is a child, indicate % where time is spent (i.e., bedroom, grandparents' home, school, 2nd home, etc.):

__________% __________% __________% __________%

How long have you lived in the Bay Area? __________

List places you have lived for more than 6 months: ______________________