KAISER PERMANENTE®

# Allergy Questionnaire

Name _____

Member ID Number _____

## Part 1: Please answer only the sections that apply to you

Age: _____ Sex: □ Male □ Female Birthplace: _____ Years in Northwest: _____

**Your main concerns:** _____

_____

**Complete this section only for: NOSE /THROAT /EARS/ EYES/ HEAD SYMPTOMS** * *If none, skip to next section*

1) Check all that apply **and circle** the ones that bother you the most:

| **Nose** | **Throat** | **Ears** | **Eyes** | **Head** |
|---|---|---|---|---|
| □ itchy nose<br>□ sneezing<br>□ congestion<br>□ decreased smell/taste<br>□ snoring<br>□ runny nose - if yes, is the *nasal discharge:*<br>□ *clear* □ *colored* | □ sore throat<br>□ itchy throat or palate<br>□ throat clearing<br>□ cough<br>□ hoarseness<br>□ post-nasal drainage – if yes, is the *drainage:*<br>□ *clear* □ *colored* | □ itchy ears<br>□ plugged ears<br>□ ringing<br>□ hearing loss | □ itchy eyes<br>□ watery eyes<br>□ red eyes<br>□ dry/irritated eyes<br>□ swollen lids<br>□ discharge | □ headache<br>□ facial pressure or pain |

2) When did your symptoms **first** begin? _____ When, if so, did they **get worse**?_____

3) Are your symptoms: □ seasonal* □ all year long □ all year long, with seasonal worsening*
** Circle the **worst months**:* Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec

4) Check the things that make your symptoms worse:

| **Irritants** | **Weather** | **Medicine** | **Allergens** | **Location** | **Other** |
|---|---|---|---|---|---|
| □ smoke<br>□ air pollution<br>□ fumes or car exhaust<br>□ strong odors or perfumes | □ cold air<br>□ rapid temperature change *(e.g. going from cold outdoors to indoor heat)* | □ aspirin<br>□ non-steroidal anti-inflammatory agents *(e.g. Motrin, Advil, Aleve)* | □ grass<br>□ dust or vacuuming<br>□ damp or musty area<br>□ animals, if so specify: _____<br>_____ | □ outdoors<br>□ indoors<br>□ daycare<br>□ home<br>□ school<br>□ work | □ _____<br>_____<br>_____<br>_____<br>_____<br>_____ |

5) Have you had any of the following **problems** or **procedures**: * *If yes, specify* □ **Yes*** □ No
□ frequent ear infections □ PE tubes □ nasal or sinus surgery □ nasal polyps
□ broken nose □ frequent sinus infections (how many in a year? _____ )

**Complete this section if: ALLERGIC REACTION TO A STING, DRUG, FOOD or other SUBSTANCE** ***If none,** *skip to next section* **If more than one reaction: answer the same questions for each reaction on a separate page**

1) **What** did you react to? _____
If stung, **where** on your body were you stung? _____
2) **When** did the reaction occur? *(date and time of day)* _____
3) **Length of time** from exposure (or sting/injection) until onset of symptoms: _____
4) **How long** did your symptoms last? _____
5) Briefly **describe** the reaction: _____
_____
_____

6) Please check any of the following **symptoms** you had with your reaction:
□ shortness of breath □ tongue swelling □ hoarseness or change in voice
□ dizziness or loss of consciousness □ wheezing or chest tightness □ throat tightness or trouble swallowing
□ flushing □ abdominal cramping, diarrhea or vomiting

7) Did you get **medical attention**? □ **Yes*** □ No
* *If yes, was it from:* □ Emergency Room □ Urgent Care □ Clinic □ 911/Medics

8) **Treatment** (if any) you received: _____

9) Do you have a **current EpiPen**? □ Yes □ No

**DO NOT SCAN THIS QUESTIONNAIRE**



**Continued on next page**

**Complete this section only for: CHEST or ASTHMA SYMPTOMS** ***If none, skip to next section***

1) Check all that apply **and circle** the ones that bother you the most:
□ shortness of breath □ wheezing □ chest pain or tightness □ coughing up blood
□ recurrent or chronic cough – if yes, is the cough: □ wet/productive □ dry

2) When did your symptoms **first** begin? _____ When, if so, did they **get worse**? _____

3) Are your symptoms: □ seasonal* □ all year long □ all year long, with seasonal* worsening?
* *Circle **worst months**:* Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec

4) **How often** do you have symptoms? □ 2 or less times a week □ once a day
□ 3–6 times a week □ throughout the day

5) Do these symptoms **disturb your sleep**? □ **Yes*** □ No
*If yes, how often? □ 2 or less times a month □ 3–4 times a month □ 2–6 times a week □ every night

6) Do your symptoms ever **interfere with exercise** or **daily activities**? □ **Yes*** □ No
* If yes, what activity? _____

7) Have your symptoms forced you to **miss work** or **school**? *(Circle which one)* □ **Yes*** □ No
* If yes, how many times in the past 12 months? _____

8) Have your symptoms caused you to go to the **Emergency Room** or **Urgent Care**? □ **Yes*** □ No
* If yes, how many visits in the past 12 months? _____

9) Have your symptoms caused you to be **admitted** overnight to the hospital? □ **Yes*** □ No
* If yes, how many times? ____ Were you ever in the Intensive Care Unit? □ Yes □ No
Have you been intubated or on a ventilator? □ Yes □ No

10) Have you ever needed treatment with an oral or injectable **steroid**? *(e.g. prednisone)* □ **Yes*** □ No
* If yes, when was your last course of steroids? _____

11) Check the things that make your **chest symptoms worse**:

| **Irritants** | **Infections** | **Weather** | **Medicine** | **Allergens** | **Location** | **Other** |
|---|---|---|---|---|---|---|
| □ smoke<br>□ fumes/car exhaust<br>□ air pollution<br>□ strong odors or perfumes | □ colds or flu<br>□ sinus infections | □ cold air<br>□ weather changes<br>□ heat | □ aspirin<br>□ non-steroidal anti-inflammatory agents *(e.g. Motrin, Advil, Aleve)* | □ grass<br>□ dust/vacuuming<br>□ damp or musty areas<br>□ animals, If yes, specify: _____ | □ outdoors<br>□ indoors<br>□ home<br>□ daycare<br>□ school<br>□ work: _____ | □ exercise<br>□ emotion/ stress<br>□ laughing<br>□ other: _____ |

12) Have you ever had pneumonia? □ **Yes*** □ No * If yes, how many times? _____

13) Have you had a **chest X-ray** since your symptoms began? □ **Yes*** □ No * If yes, when? _____

14) Do you have symptoms of **heartburn or acid reflux**? □ **Yes*** □ No * If yes, how often? _____

**If you've been prescribed albuterol or have asthma, please answer the following questions:**

1) How many **puffs** of albuterol do you use **per day**? _____

2) How many **canisters** of albuterol do you use **each month**? _____

3) Do you use a **spacer** with your inhalers? □ Yes □ No

4) Do you monitor your **peak flows**? □ **Yes*** □ No
* If yes, what is your **personal best peak flow**? _____
* What has been the **range** of your peak flow readings over the past 2 weeks? _____

**Complete this section only for: ECZEMA** ***If none, skip to next section***

1) When did your eczema **first** begin? _____ When, if so, did it **get worse**? _____

2) What **parts of your body** are most affected? _____

3) Are your symptoms: □ seasonal* □ all year long □ all year long, with seasonal worsening*
**Circle **worst months**:* Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec

4) Check the things that make your **eczema worse**:

| **Irritants** | **Allergens** | **Foods** | **Other:** |
|---|---|---|---|
| □ soaps □ tight clothing<br>□ detergents □ cosmetics<br>□ wool □ sun<br>□ heat | □ dust □ mold<br>□ pollen<br>□ animals: _____ | □ milk □ nuts □ soy<br>□ wheat □ eggs □ peanuts<br>□ other: _____ | □ Infection<br>□ _____ |

**DO NOT SCAN THIS QUESTIONNAIRE**



**Continued on next page**

**Complete this section only for: HIVES or SWELLING** ***If none, skip to next section***

1) What is your main **problem**? ☐ hives ☐ swelling ☐ hives and swelling

2) What **parts of your body** are affected? _____

3) When did your symptoms **first** begin? _____ When was your **last outbreak**? _____

4) On the average, **how long** does each outbreak last? _____

5) **How often** do outbreaks occur? ☐ daily ___ times a week ___ times a month ___ times a year

6) **If you have hives, how long** does each individual hive last? ☐ less than 24 hours ☐ more than 24 hours

7) Check any **symptoms you have with hives**: ☐ itching ☐ burning ☐ tingling ☐ pain ☐ bruising

8) Check all that apply: Symptoms worse in the: ☐ spring ☐ summer ☐ autumn ☐ winter
Symptoms worse in the: ☐ morning ☐ afternoon ☐ evening ☐ night
Symptoms worse in the: ☐ outdoors ☐ indoors ☐ home ☐ school ☐ daycare ☐ work
Symptoms worse during: ☐ weekdays ☐ weekends ☐ menstrual cycle

9) During an outbreak, do you have any of the following **symptoms**? ☐ **Yes*** ☐ No * *If yes, check box.*
☐ shortness of breath ☐ flushing ☐ tongue swelling ☐ throat tightness or trouble swallowing
☐ wheezing or chest tightness ☐ hoarseness or change in voice ☐ dizziness or loss of consciousness
☐ joint pain ☐ fever ☐ swollen glands ☐ diarrhea, vomiting or abdominal pain

10) Check the things that make your **symptoms worse**:

| **Exposure to:** | **Medicines** | **Allergens** | **Other** |
|---|---|---|---|
| ☐ exercise<br>☐ cold air<br>☐ sunlight<br>☐ heat (shower/bath)<br>☐ rubbing or scratching<br>☐ vibration (mowing lawn, motorcycling) | ☐ aspirin<br>☐ non-steroidal anti-inflammatory agents (e.g. Motrin, Advil, Aleve)<br>☐ ACE inhibitors (e.g. lisinopril)<br>☐ other medicines:<br>_____ | ☐ grass<br>☐ dust or vacuuming<br>☐ wooded areas<br>☐ damp or musty area<br>☐ latex (balloons, condoms, dental work, latex gloves)<br>☐ animals, specify:<br>_____<br>☐ foods or food additives, specify:_____ | ☐ emotion or stress<br>☐ other: _____ |

11) Check the box if the following **events** happened soon before your symptoms started:
☐ mononucleosis ☐ jaundice or hepatitis ☐ sore throat or strep throat ☐ sinus infection
☐ swollen lymph glands ☐ urinary tract infection ☐ toothache or gum infection ☐ bee sting
☐ pneumonia ☐ thyroid problems ☐ ulcers or gastritis
☐ fungal infection of skin, scalp, or nails ☐ impetigo or skin infection
☐ transfusion ☐ immunization, specify: _____
☐ recent move from another area; from where? _____
☐ job change, specify: _____
☐ change of residence ☐ foreign travel, where? _____
☐ other: _____

## Part 2: Please answer all of the remaining questions

### Medicines

List **all** prescription and over-the-counter medicines you're currently taking that you **do not receive through Kaiser Permanente.** Include oral, inhaled, injected, drops, sprays, suppositories, creams and ointments.

| Name of medicine | Strength (if known) | Dose and number of times taken per day |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

**Attach separate list if necessary.**

### Allergy History

1) Have you had previous allergy **skin testing**? ☐ **Yes*** ☐ No * *If yes, when?* _____

2) Have you ever received **allergy shots**? ☐ **Yes*** ☐ No * *If yes, specify the years you received them:*
From _____ to _____ Additional years: From _____ to _____ From _____ to _____
Were the shots helpful? ☐ Yes ☐ No Did you have any bad reactions? ☐ Yes ☐ No

3) Do you have allergies to any foods? ☐ **Yes*** ☐ No * *If yes, specify:*

| Name of food | Allergic reaction(s) | Approximate date of reaction(s) |
|---|---|---|
| | | |
| | | |
| | | |

**DO NOT SCAN THIS QUESTIONNAIRE**



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## Past Medical History

1) Check the box if you've had any of the following:
□ glaucoma □ cataracts □ depression □ high blood pressure
□ diabetes □ tuberculosis □ positiveTB test □ peptic (stomach) ulcer
□ AIDS or HIV □ kidney disease □ aseptic necrosis □ osteoporosis □ heart problems
□ other significant medical problems: _____

2) Please list all **surgeries and hospital stays:** (followed by approximate date)

_____ _____ _____
_____ _____ _____
_____ _____ _____

3) Have you **ever smoked**? □ **Yes*** □ No * *If yes, specify.*
Are you: □ a **current** smoker? □ a **past** smoker? **Quit date:** _____
**What** and **how long** did you smoke? □ cigarettes: ____ years **Packs per day:** _____
□ cigars: ___ years □ pipe: ___ years

4) Does **anyone** in your home smoke? □ **Yes*** □ No * *If yes, specify.*
□ mother □ father □ spouse or partner □ son □ daughter
□ brother □ sister □ roommate □ other: _____

## Family History

**Please place a check mark for each relative with the following medical problems:**

* *If more than one relative has the same medical problem, place a check mark for each one.*

*Example: 2 brothers with asthma:*

| *Medical Problem* | *Mother* | *Father* | *Brother* |
|---|---|---|---|
| *Asthma* | | | ✓✓ |

| Medical Problem | Mother | Father | Brother | Sister | Son | Daughter | Grandmother | Grandfather |
|---|---|---|---|---|---|---|---|---|
| Asthma | | | | | | | | |
| Emphysema | | | | | | | | |
| Nasal allergy | | | | | | | | |
| Sinus problems | | | | | | | | |
| Eczema | | | | | | | | |

## Environmental History

1) What is/was your **occupation** or, if you are still a student, your **grade** in school? _____
2) What are your **hobbies**? _____
3) **How long** have you lived at your present location? _____ years
4) **Location**: □ downtown □ urban □ suburb □ rural/country
5) **Type of home**: □ house □ apartment/condo □ houseboat □ mobile home □ other: _____
6) **Where** do you live? *(City, town, city neighborhood, or nearest city)?* _____
7) **Type of heating**: □ radiant □ forced air □ heat pump □ wood burning stove □ pellet stove □ other: _____
8) **Air conditioning**: □ none □ central □ window units
9) **Air filter**: □ HEPA □ electrostatic
10) **Floor**: Bedroom: □ carpeting □ wood/laminate □ tile □ cement □ other: _____
Family room: □ carpeting □ wood/laminate □ tile □ cement □ other: _____
11) **Mattress**: □ regular □ foam □ air mattress □ waterbed □ futon □ other: _____
12) **Pillow**: □ synthetic □ foam □ down □ feather □ cotton □ other: _____
13) **Comforter**: □ none □ down □ synthetic □ feather □ other: _____
14) Do you have zippered dustmite **allergy covers (encasements)**? □ **Yes*** □ No * *If yes, what item is covered?*
□ pillows □ mattress □ comforter □ box springs
15) Do you have any **pets**? □ **Yes*** □ No * *If yes, check all that apply and how many of each animal.*
□ cat(s) #___ □ dog(s) #___ □ bird(s) #___ □ guinea pig(s) #___
□ gerbil(s) #___ □ hamster(s) #___ □ rabbit(s) #___ □ other: _____
**Circle** all pets that live in or have access to your (or the patient's) bedroom.
16) Do you have a **mold** or **mildew** problem in your home? □ Yes* □ No *If yes, is it a □ minor problem? □ major problem?
Where is it? □ bathroom □ basement □ kitchen □ window sills □ other: _____

# Thank you