Metropolitan Allergy and Asthma, PC
34 Sycamore Ave. Suite 1A
Little Silver, NJ 07739
Phone: (732) 383-5554
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Allergy Questionnaire

Date: _____

Please complete this questionnaire and remember to bring it with you for your first visit.
The purpose of this questionnaire is to obtain the most complete and accurate history of your allergy problems. Many of the questions may not deal directly with your specific problem, but please answer all the questions which pertain to you and your general health. If you have x-rays, CT scans or laboratory tests that relate to your health problem(s), please bring them with you to your appointment or have your doctor send them to our office prior to your appointment.

Please do not take any anti-histamine medications for 2 days before your visit for allergy testing. This includes such medications Benadryl (diphenhydramine), Atarax (hydroxyzine), Claritin (loratadine), Zyrtec (cetirizine), Allegra (fexofenadine), Clarinex (desloratadine) and Xyzal (levocetirizine). Many over-the-counter cold, cough and allergy medications also contain anti-histamines. Please feel free to call our office if you are unsure if a medication contains an anti-histamine. If you feel that you **cannot** discontinue your anti-histamine(s) for 2 days prior to your visit, please contact our office to let us know before your appointment.

Name: _____ Sex: M _____ F_____

Date of Birth: _____

Consulting Physician - Please fill out the information below if you have a referring physician.

Doctor's Name: _____ Phone: _____

Address: _____ Fax: _____

Reason for your visit

What is the main reason for your visit to our Allergy and Immunology clinic? How long have you had this problem?

_____

_____

Please list the approximate dates and findings of any previous allergy testing and evaluation:

_____

_____

If you have received allergy injections in the past, please list the years you received them:

_____

Past Medical History

Birth Weight and Gestational Age (40 weeks is full term) _____

Have you had the following diseases or conditions? (If yes, when did it start?)

	Yes	No	
Illness at birth	___	___	_____
Whooping Cough	___	___	_____
Croup	___	___	_____
Diabetes	___	___	_____
High Blood Pressure	___	___	_____
High Cholesterol	___	___	_____
Cataracts or glaucoma	___	___	_____
Thyroid disease	___	___	_____
Heart Disease	___	___	_____
Heartburn or reflux	___	___	_____
Osteoporosis	___	___	_____
Liver disease	___	___	_____
Kidney disease	___	___	_____

Other medical problems not mentioned above: _____

Infection History

Circle if yes: blood infection, bronchitis, pneumonia, sinusitis, chickenpox (or varicella vaccine), hepatitis, HIV, ear infections, meningitis (brain infections), sexually transmitted disease, shingles (zoster), urinary tract infection
Other: _____

Previous Hospitalizations/Surgeries/Emergency Department visits

Year	Procedure or Reason for hospital or Emergency Department visit

Drug Allergy: Please briefly describe any known allergies to drugs below.

☐ Penicillin: _____

☐ Sulfa drugs: _____

☐ NSAIDs (aspirin, ibuprofen (Motrin, Advil), naproxen, etc.) _____

☐ Other: _____

☐ None (I am unaware of any drug allergies)

Family History

	Mother	Father	Brother	Sister	Son	Daughter	Others
Seasonal Allergies (Hay Fever)							
Asthma							
Eczema							
Immune deficiency							
Other Diseases:							
(1) _____							
(2) _____							

Social & Environmental History (Please circle when appropriate)

- What pets or animal exposure do you have? _____
- Do you smoke? YES NO: If Yes, age when you started? _____
  If No, have you ever smoked? YES NO Quit? _____
- Is there anyone at home who smokes? YES NO Where? INSIDE OUTSIDE
- Do you drink alcohol? YES NO: If Yes, how often and how much? _____
- How long have you lived in NJ ? _____
- Type of home: Single house Townhouse Apartment Mobile Home Dorm
- Location of home: City Suburb Rural
- Type of heat: Heat pump, Baseboard, Gas, Oil, Electric, Fireplace, Wood-burning stove, Kerosene space heaters
- Do you have any: water damage, fire damage or excess mold or mildew?
- In the bedroom, do you have: wall to wall carpeting, air conditioning, air filters, or wood flooring?
- What type of work do you do? Or, if you are a student, please tell us what grade/level of education:
  _____
- Is your work/school related to the problem you are here for today? Yes No
- How often were you absent from work or school during the last 12 months due to the health problem(s) you are being seen for? _____

Current Medications

Include all prescribed & over-the-counter medications, vitamins, dietary supplements, antacids, Tylenol, Advil etc.

NAME	DOSE	HOW MANY TIMES PER DAY	LENGTH OF TIME TAKEN

Pharmacy Name & Phone Number: _____

Name:	DOB:	Chart No.:

Allergy History

Foods:	Yes	No	Reaction or Symptoms:
Tree nuts (ex. walnuts, pecans, almonds)	___	___	_____
Peanuts	___	___	_____
Fish	___	___	_____
Shellfish (shrimp, crab, lobster)	___	___	_____
Milk	___	___	_____
Egg	___	___	_____
Wheat	___	___	_____
Soy	___	___	_____
Melons, Bananas	___	___	_____
Apples, Peaches, Cherries	___	___	_____
Other: _____	___	___	_____

Animals/Bee stings:	Yes	No	Reaction or Symptoms:
Cats	___	___	_____
Dogs	___	___	_____
Horses	___	___	_____
Bee Stings (i.e. bees, wasps/hornets, fire ants)	___	_____	
Other: _____	___	___	_____

Other Substances	Yes	No	Reaction or Symptoms:
Latex	___	___	_____
Nickel, other metal: _____	___	___	_____
Radiocontrast dye	___	___	_____
Other: _____	___	___	_____

Review of Symptoms

		Yes	No
Constitutional	Have you experienced weight loss?	___	___
	Do you have recurrent unexplained fevers and/or chills?	___	___
Eyes	Do you have watery or itchy eyes?	___	___
	Do you have burning, redness or discharge?	___	___

Review of Symptoms, continued

		Yes	No
ENMT	Do you have ear pain or pressure?	___	___
	Do you have sinus pain or pressure?	___	___
	Do you have loss of smell?	___	___
	Do you have lip swelling or tongue swelling?	___	___
	Do you have a constant sore throat?	___	___
Heart	Do you have skipped beats or palpitations?	___	___
	Do you have chest pain or tightness?	___	___
	Do you have any loss of consciousness or black-outs?	___	___
Respiratory	Do you have a persistent cough?	___	___
	Do you wheeze?	___	___
	Have you ever coughed up blood?	___	___
	Do you have shortness of breath?	___	___
	• At rest?	___	___
	• With exercise?	___	___
	• Wakes you up from sleep?	___	___
Gastrointestinal	Do you have heartburn or reflux?	___	___
	Do you have abdominal pain?	___	___
	Do you have vomiting or diarrhea?	___	___
	Do you have any bloody stools or black tarry stools?	___	___
Genitourinary	Do you have painful or unusually frequent urinations?	___	___
	Do you have any blood in urine?	___	___
Musculoskeletal	Do you have any joint swelling?	___	___
	Do you have any joint pain or muscle aches?	___	___
Skin	Do you have any skin rashes?	___	___
	Do you have any swelling or hives?	___	___
	Do you have any itching?	___	___
	Do you have any dryness or cracking?	___	___
Neurologic	Do you have migraines or headaches?	___	___
	Do you have any dizziness or ringing in ears?	___	___
	Do you have any visual changes?	___	___
Psychiatric	Are you bothered by depression or anxiety?	___	___
Endocrine	Have you become unusually thirsty recently?	___	___
	Do you sense room temperature differently from others?	___	___
Hematologic/Lymphatic	Do you tend to bruise or bleed easily?	___	___
	Do you feel weak and tired easily?	___	___
	Do you have any swollen lymph nodes?	___	___
Immunologic	Do you get frequent infections requiring antibiotics?	___	___

Patient/Parent/Guardian Signature: _____ **Date:** _____

(Please Stop Here)

Allergy Questionnaire Reviewed by: _____ **MD** **Date:** _____

Name:	DOB:	Chart No.: