TEXAS FAMILY WELLNESS CLINIC

Allergy Questionnaire

First Name: _____ M.I. _____ Last Name: _____

Date of Birth: _____

Do you believe you have allergies? _____ yes / _____ no

If so, what do you think you are allergic to? _____

If given the opportunity, would you like to have allergy testing done? _____ yes / _____ no

Have you ever had any of the following problems or symptoms? (check all that apply)

- ❑ Hives or swelling, how often? _____
- ❑ Breathing problems, weezing, or coughing? _____
- ❑ Have you been diagnosed with asthma? _____ at what age? _____
- ❑ Do you have any indoor pets? _____ if yes, how many & what type? _____
- ❑ Skin Problems, eczema or other rashes? _____
- ❑ Sinus trouble, hay fever? _____
- ❑ Runny, stuffy, itchy nose, how often? _____
- ❑ Sneezing often? _____
- ❑ Headaches, migraines, dizziness? _____ how often? _____
- ❑ Ear pain or pressure? _____
- ❑ Itching in the ears/throat, how often? _____
- ❑ Watery or itchy eyes? _____
- ❑ Frequent sinus or throat infections, how often? _____
- ❑ Food reactions? Which foods & describe _____
- ❑ Drug reactions? Which drugs & describe _____
- ❑ Insect reactions? Which insects & describe _____

Have you ever taken any medication for the above symptoms? ____ Yes _____ No

If yes, which medications have you tried & if/how they worked for you to relieve symptoms

_____

When is the last time you took any of the above mentioned medications? _____

Have you ever had an allergy skin test? _____ allergy shots? _____ did they work? _____

If yes, date _____ Physician's Name _____

Do you suffer from uncontrolled asthma or reduced lung function? ____ Yes ____ No

Have you had a severe allergic reaction or anaphylaxis reaction? ____ Yes ____ No

Have you ever been hospitalized due to uncontrolled allergies? ____ Yes ____ No

Do you suffer from any cardiovascular disease? ____ Yes ____ No

Do you take any beta blockers to treat your heart disease? ____ Yes ____ No