

NATHAN TANG, MD
 ALLERGY ASTHMA ASSOCIATES, PA
 333 Dr ML King Jr St N, St. Petersburg, FL 33701
 Tel: (727) 825-0111 Fax: (727) 825-0011

ALLERGY QUESTIONNAIRE

INSTRUCTION: Please answer these questions as they relate to you or your child (the patient). Complete information is very helpful in learning about you or your child's allergy problem. Please bring this completed form to your first appointment.

Patient's Name	Date of Birth
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1. MAIN CONCERNS (Chief Complaint):

Briefly, describe the reason for your allergy visit and what you hope to accomplish:

2. PROBLEMS: Have you/your child ever had any of the following?						
Yes	Please CHECK ALL items that apply	How severe?			How long (mo, yr)?	Comments
		Mild	Moderate	Severe		
<input type="checkbox"/>	Asthma (wheezing or coughing)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/>	Other breathing problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/>	Sinus trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/>	Hay fever (runny, stuffy, or itchy nose)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/>	Itchy, watery or red eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/>	Hives or swelling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/>	Eczema or other rashes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/>	Frequent infections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		

3. ALLERGIC REACTIONS:

Have you/your child ever had any symptoms (rash, hay fever, vomiting, diarrhea, coughing or wheezing) after having the following items below? If yes, explain:

Yes	What type?	Dates and Symptoms
<input type="checkbox"/>	Food:	
<input type="checkbox"/>	Medicine:	
<input type="checkbox"/>	Vaccine:	
<input type="checkbox"/>	Insect bite:	
<input type="checkbox"/>	Latex or X-ray dye:	

4. TRIGGERS:

For each item below, check the appropriate square to indicate whether you/your child is affected by the following:

	Symptoms worse	Symptoms Improved	No change		Symptoms worse	Symptoms improved	No change
Cutting or playing in grass	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Medicines:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other outdoor activities: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	•Antihistamines or cough/cold medicine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Moldy/mildewed areas (basement, attic, etc)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	•Asthma medicine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sweeping, dusting or vacuuming	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	•Nose drops or spray	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Smog or smoke exposure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Summer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Air conditioning or heating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Spring	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chemicals, strong odor, perfume, soap, detergents, or other: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Winter	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Trips away from home or while at school	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Exposure to animals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	"Colds" or viruses	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Other factors: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

5. PREVIOUS ALLERGY EVALUATION & TREATMENT:

Have you/your child had previous allergy skin tests or blood test? Yes No

If Yes, Where? _____ Doctor's name? _____

Results of these tests (if possible, provide us with a copy)

Have you/your child ever received allergy shots? Yes No If Yes, From _____ to _____ (mo/yr)

6. MEDICATIONS:

Please list all medicines you are now taking.
Please bring all of these with you for your appointment.

Name	Dosage	Name	Dosage
1. _____	_____	5. _____	_____
2. _____	_____	6. _____	_____
3. _____	_____	7. _____	_____
4. _____	_____	8. _____	_____

7. OTHER MEDICAL PROBLEMS:Have you ever had any of the following? (Check All Items that apply)**Yes**

- Frequent headaches
 Frequent nosebleeds
 Nasal polyps
 Operation on sinuses
 Hearing problems
 Glaucoma
 Frequent ear infections
 Pneumonia

Yes

- Diabetes
 Coughed up blood
 Sinus X-Rays, CT scans
 Chest X-ray
 Heart trouble
 High blood pressure
 Colic or spitting up (as infant)
 Frequent heartburn

Yes

- Frequent diarrhea
 Sexual problems
 Liver trouble (e.g. hepatitis)
 Kidney or bladder trouble
 Poison ivy
 Skin infections
 Other? _____

8. HOSPITALIZATIONS:

List most recent first

Reason

Date

1.
2.
3.

9. SURGERY:

List most recent first

Reason

Date

1.
2.
3.

10. FAMILY HISTORY:

Do any members of your family have a history of allergies?

Yes

If YES, list all relatives (parents, brothers, sisters, children, aunts, uncles, and grandparents).

- Asthma
 Hay fever
 Eczema
 Hives or swelling
 Any immune diseases
 Frequent pneumonia or lung diseases
 Cancer
 Cystic fibrosis
 Tuberculosis
 Thyroid disease
 Glaucoma
 Diabetes

11. ENVIRONMENTAL SURVEY:

Where do you live? City County Do you **own** or **rent** your home? How old is your home? _____
House Apartment Are any rooms damp or musty? **Yes** **No**

Please check the boxes if you have the following items in these rooms in the house:

	Bedrooms	Living Room	Dining Room	Other Rooms
Carpet?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Area rug?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ceiling fan?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Central air condition?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Is your pillow: Feather
 Encased in plastic
 Other _____

Is your mattress: Innerspring and cotton
 Encased in plastic
 Other _____

Do you have any: Stuffed furniture? **Yes** **No** Feather blankets? **Yes** **No**

What kinds of grasses, shrubs and trees are near your house? _____

Do you have pets? **Yes** **No** List number and kind (dog, cat, birds, horses, etc.) _____

12. WORK ENVIRONMENT:

Do you work or go to school? **Yes** **No**

What type of work do you do? _____

Are you exposed to anything at work or school that makes these symptoms worse? **Yes** **No**

What things? _____

Have you missed any time from work or school because of allergies? **Yes** **No** How many days in the last year? _____

Does your sports, hobbies, recreations or other activities make these symptoms worse? **Yes** **No**

13. MARITAL STATUS:

Married Single Divorced Widowed Separated Number of children: _____

14. SMOKING HISTORY (PARENTS AND/OR PATIENT):

Have you ever smoked? **Yes** **No** How many years? _____

Do you smoke now? **Yes** **No** If No, when did you stop? _____ If Yes, how many cigarettes per day? _____

COMPLETED BY: _____
Patient or Parents

REVIEWED BY: _____
Nathan Tang, MD

BRING THIS COMPLETED FORM WITH YOU FOR YOUR FIRST APPOINTMENT. THANK YOU