NORTH KITSAP EAR, NOSE AND THROAT
KITSAP ALLERGY CARE
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ALLERGY QUESTIONNAIRE

{provider comments}

Today's Date:______________________________

Patient:___________________________________ Date of Birth:_______________________

1. Have you ever experienced a reaction that caused breathing trouble OR swelling of lips/tongue?
   □ Yes □ No

2. Have you ever had any of the following:

Yes	No	Problems	Age of Onset	Comments
		Nasal allergy symptoms (runny, stuffy, itchy nose, sneezing)		
		Recurrent sinus infections		
		Asthma (wheezing) or any inhaler use		
		Eczema or other rashes		
		Latex allergy		
		Vaccine allergy		
		Nut allergy		
		Stinging Insect Allergy		

3. Have you ever had the following symptoms (If answer is no, leave blank)?

	Severity		
	Mild	Mod.	Severe
Sneezing			
Itchy nose			
Runny nose			
Dripping sensation at the back of the throat			
Throat clearing			
Nasal congestion			
Ear pain/ popping/ fullness			
Red eyes			
Itchy eyes			
Watery eyes			
Headaches			
Sinus pain or pressure			
Discolored nasal drainage			
Decreased sense of smell			

4. Are there any factors that obviously trigger your asthma or allergy symptoms?

	Unsure	Yes	No
cats			
dogs			
feathers			
grasses			
trees			
weeds			
house dust			
mold OR mildew			
exercise			
smoke			
strong odors			
house plants			
changes in temperature			
other (i.e., animals, etc.):			

{provider comments}

5. Environmental.

Occupation:________________________ □indoors □outdoors

Place of Birth_______________________ Years in Pacific Northwest___________________

Location of home: □suburbs/city □rural/country

Type of dwelling : □house □apt/condo □dorm □motor/mobile home

Flooring: □carpet □hardwood □ tile

Heating Type: □central □fireplace □ stove □ wood □ space heater

Bedroom: □carpet □pets allowed in bedroom

Bedroom Mattress: □standard □foam use encasement (mark one): □ Yes □ No

Bedroom Pillows: □synthetic □feather use encasement (mark one): □ Yes □ No

Pets (indicate #): _______ cat(s) _______ dog(s) _______ other

Hobbies (wood working, gardening, running, etc.): ______________________________

6. Family History.

Do any members of your biologically related family have history of the following?

	Yes	No	If yes, list all relatives (e.g. parents, brothers, sisters, children, aunts, uncles, grandparents, etc .)
Asthma			
Allergic rhinitis ("hay fever" / nasal allergies)			
Atopic Dermatitis or Eczema			
Hives			
Ear tubes or sinus surgeries			

7. When are allergy symptoms present (mark one):

- □ Throughout the year.
- □ Particular month(s)/season(s); which are worse?__________________________

8. Have you ever had allergy testing? □ Yes □ No

If yes, Physician's Name: ____________________ Results:_____________Appx. Year: ___________

9. Have you ever received allergy injections? ☐ Yes ☐ No

If yes, date(s): ________________________ Were they of any benefit? ☐ Yes ☐ No

10. List any medications you have tried for your allergies or asthma (including all nasal, oral or eye drop medication).

Medication	Dose	Frequency (daily, etc.)	Length of Use?	Effectiveness (check one)				Side effects
				No Help	Helped little amount	Helped moderate amount	Completely relieved symptoms	

{provider comments:}