KAISER PERMANENTE ®

The Permanente Medical Group, Inc.

ALLERGY, ASTHMA & IMMUNOLOGY QUESTIONNAIRE

Please complete and check all that apply

Name: _____ MR#: _____ Age _____ Date _____

Home phone: _____ Work phone: _____ Cell phone: _____

Occupation: _____

1. Who referred you to the Allergy Department? _____
2. Which **allergy** related symptoms bother you the most? _____
3. How long have you lived in the Bay Area? _____ at your present address? _____

CURRENT SYMPTOMS AND COMPLAINTS – PLEASE CHECK (√) ALL THAT APPLY

CHEST	NOSE	EARS	EYES	THROAT	SKIN
__ Asthma __ Cough __ Wheeze __Tightness __ Shortness of Breath	__ Itching __ Congestion __ Sneezing __ Running	__ Itching __ Blockage	__ Itching __ Tearing	__Itch/Tickle __ Hoarseness __ Post Nasal Drip	__ Dry Skin __ Hives __ Rash

-Are you worse with __Dust/Dust mite __ Animals __ Mold/Mildew __ Pollen __ Exercise

__Odors/Scents __Respiratory Infections __ Smoke/Fireplace __ Indoors __Outdoors __Other

-Are you better with __ Indoors __ Outdoors __ Vacations __ Exercise __ Medications

4. When did your symptoms begin? _____
5. When are your symptoms present? __Year-long __ Seasonal __ Other_____
6. How would you describe your symptoms? _____
7. Severity of your symptoms on a scale of 0 -10? (**0 is normal, 10 is very severe**) _____
8. How many days have you missed from work/school because of your symptoms in the past year? _____

OTHER ALLERGY PROBLEMS

1) Please describe any **medication allergies** _____

2) Please describe any **food allergies** _____

2) Have you had a reaction to mango, apple, chestnut, kiwi, avocado, hazelnut, banana, melon, papaya? __ No __ Yes

4) Have you had a reaction with rubber/latex i.e. pacifier, gloves, balloons, condoms, diaphragm? __ No __ Yes

5) Do you or your co-workers wear latex/rubber gloves or are you exposed to latex in any way? __ No __ Yes

6) Have you had a **severe** reaction to a bee, wasp, or hornet sting? __ No __ Yes

ASTHMA PLEASE COMPLETE ONLY IF YOU HAVE ASTHMA

How would you rate your asthma on a scale of 0 -10? (**0 is normal, 10 is very severe**) _____

Do you have? __Peak Flow Meter __ Asthma Self-Management Plan __ Spacer Device

How many times have you:	total # times	# in past 12 months
- gone to the Emergency Room or Urgent Care for asthma?	_____	_____
- taken prednisone / cortisone "burst" for asthma?	_____	_____
- had a hospitalization for asthma?	_____	_____
- been admitted to the ICU for asthma?	_____	_____

FAMILY HISTORY: List relatives with nasal allergies, asthma, food allergy, eczema OR other allergic disease

_____

PAST MEDICAL HISTORY

__ Glaucoma, Cataracts
__ Nasal Polyps
__ Lung Problem
__ Heart Disease
__ High Blood Pressure
__ Heartburn/ Hiatal Hernia
__ Liver Disease, Hepatitis
__ Kidney Problems
__ Currently Pregnant
__ Menopause
__ Diabetes
__ Neurological Problem
__ Thyroid Disease
__ Mental Health Disorder
__ Cancer
__ HIV/AIDS
__ Has anyone ever said you stopped breathing while sleeping?

Hospital/surgery/Emergency Department visits

_____

_____

_____

SOCIAL HISTORY

1) Marital Status: __ Single __ Married __ Divorced __ Widow __ Partnered __ Separated __ Other _____

2) Please list your hobbies: _____

3) Spouse/Partner's Occupation - *if applicable*: _____

4) Smoking history: __Currently __Previously smoked: Date quit _____ __Years smoked _____
   How many per day: Cigarettes _____ (Packs) Cigars _____ Pipes _____
   __Live with smoker __ Never smoked
   If you still smoke, are you interested in quitting in the next 6 months? __ No __ Yes

5) Do you drink alcohol? __ Never __ Former __ Regular __ Occasional __ Rarely
   __Red/White Wine __ Beer __ Other _____ **Amount per day or per week** _____

6) Do you use recreational drugs? __ Yes __ No Please specify _____

7) Please specify if you or anyone else ever been concerned about your alcohol/drug use _____

WORK/SCHOOL - ***Please list most recent employer / school.***

1) Job Title _____ Years performed/attended _____

2) Where do you work or attend school? _____

3) Describe your work or major field of study? _____

4) If work/school affects your allergies, please describe _____

ENVIRONMENTAL EXPOSURE
AREA/DURATION -*List the places you have lived for more than 2 years.*

_____

_____

1) Living Quarters: __ Apartment __ Flat __ House __ Condominium __ In-law Apartment __ Other _____

Pillow	Blanket	Mattress	Flooring	Windows	Animals
__ Synthetic __ Feather __ Foam/Rubber	__ Down __ Wool __ Synthetic __ Cotton __ _____	__ On Frame __ Standard Mattress __ Box Spring __ Water Bed __ Futon __ Foam rubber __ _____	__ Wall-to-Wall Carpeting __ Area Rug __ No Carpeting __ _____	__ Blinds __ Shades __ Curtains __ Drapes __ _____	__ Cat #___ __ Dog #___ __ ____ #___

Other	Heating
__ Roof Leak __ Roaches __ Mold __ Stuffed Animals __ Open Bookcases __ Clutter __ Plants __ _____	__ Central Heat __ Wall/Space Heater __ Fireplace in BR __ Bedroom Vent __ _____

CURRENT MEDICATIONS: Please list all medications including topical, vitamins and herbal supplements

REVIEW OF SYSTEMS

__ Unexpected weight loss	__ Leg swelling	__ Loss of consciousness
__ Blurred Vision	__ Vomiting	__ Hallucinations
__ Nosebleeds	__ Change in urinary habits	__ Bleeding problems
__ Coughing up blood	__ Falls	__ Excessive thirst