Allergy Immunology Clinic of East Bay
2320 Woolsey St/ off Telegraph Ave, Berkeley, CA 94705
(925) 270- 5119

ALLERGY QUESTIONNAIRE

(you can type in grey fields)

Patient Name	Date

How did you find us? Physician (name) Website Self referral Other

What concerns would you like to address?

When did symptoms begin?
Are symptoms getting worse? ☐ Yes ☐ No
Did you see any other Doctor or Natural Doctor for this problem? ☐ Yes ☐ No
How would you like to be treated? ☐ Traditional ☐ Natural ☐ Natural medicine

Circle what applies to you:

Eyes, nose throat	Lungs	Digestion	Skin	General	Immune
Tearing	Cough	Abdominal pain	Rash	Headache	Frequent colds
Eye swelling/redness	Troubles breathing	Constipation	Itching	Fatigue	Frequent ear infections
Eye itching	Sputum	Diarrhea	Hives	Night sweats	Skin infections
Sinus infections	Chest pain	Reflux	Acne	Weakness	IVIG infusions
Ear pain	Tight throat	Weight gain	Mastocytosis	Muscle cramps	Frequent antibiotics
Hearing loss	Wheezing	Weight loss	Fragile hair	Sleep problems	Autoimmune disease
Sore throat	Sound breathing	Heartburn	Kelloid	Cold intolerance	Anemia
Postnasal drip	Snoring	Bloating	Baldness	Depression	Pneumonia
Congestion	Trouble swallowing	Gluten intolerance	Nail problems	Anxiety	Fever
Sneezing		Food allergy	Poison oak	Bruises	Large spleen
Hoarsness		Liver problems		Cancer	Large lymph nodes

Are your symptoms seasonal ☐ YES ☐ NO ☐ Year-round
Check any of the following which seem to trigger (or cause) symptoms:
☐ Indoor ☐ Outdoor ☐ Odors ☐ Exercise ☐ Dust ☐ Perfumes ☐ Smoke
☐ Mold/Mildew ☐ Stress ☐ Alcohol ☐ Coffee ☐ Red wine ☐ Cosmetics ☐ Other

List any food allergies and reactions experienced:

List any drug allergies (i.e. penicillin, aspirin, sulfa, latex, etc.):

Describe any reaction to insect stings:

Occupation (current or former) _
Any harmful exposure at work or school:__
Do you smoke? ☐ Yes ☐ No How much? _

Have you been skin tested? ☐ Yes ☐ No
Have you had allergy shots? ☐ Yes ☐ No
Have you received oral steroids (prednisone, etc.) drugs? ☐ Yes ☐ No
When _____ How long____
Have you had ear, nose or sinus surgery ☐ Yes ☐ No

Current medications (use space at the end if this space is not enough):

Drug name	Dose (mg, units)	Frequency (times per day, week)

All supplements, herbs:

Name	Dose (mg, units)	Frequency (times per day, week)

ENVIRONMENTAL SURVEY (complete only if you have allergies)

Do you live in a ☐ House ☐ Apartment How long?
Approximately how old is your house/apartment? Do you have basement? ☐ Yes ☐ No Did you have water leaks, mold? ☐ Yes ☐ No
Type of heating system (check one) ☐ Hot Air ☐ Steam (radiator) ☐ Electric
Do you have: Have you had ear, nose or sinus surgery ☐ Yes ☐ No
Wood /Coal Stove ☐ Humidifier ☐ Dehumidifier ☐ Air cleaner
Pets (number) ☐ None ☐ Cats ☐ Dogs ☐ Birds ☐ Other
Are there any tobacco smokers in your home? ☐ Yes ☐ No
Do you have allergy proof encasing for pillow or mattress☐ Yes☐ No
What type of pillows do you have? How old is your mattress?
What type of comforter do you have?

What floor do you have in your bedroom? ☐ Carpet ☐ Hardwood ☐ Other

YOUR PAST MEDICAL HISTORY

Check all that apply:

☐ Diabetes
☐ Peptic ulcer
☐ Cancer
☐ Thyroid disease
☐ High blood pressure
☐ Arthritis
☐ Anemia/blood disorder
☐ Depression
☐ Kidney/bladder disease
☐ Diarrhea
☐ Back problems
☐ Cataracts
☐ Liver disease/hepatitis
☐ Heartburn/reflux
☐ Heart problems/murmur
☐ Seizures
☐ Osteoporosis
☐ Migraines
☐ Asthma
☐ Loss of hearing
☐ Gynecologic problems
☐ Anxiety
☐ Glaucoma

If yes to any of the above, please explain:
Please list any hospitalizations regardless of cause:
Have you had your tonsils or adenoids removed? ☐ Yes ☐ No

FAMILY HISTORY

	FATHER	MOTHER	CHILDREN	SIBLINS	OTHER RELATIVE
Nasal allergy	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐
Food allergy	☐	☐	☐	☐	☐
Eczema	☐	☐	☐	☐	☐
Contact reactions	☐	☐	☐	☐	☐
COPD/Cystic fibrosis	☐	☐	☐	☐	☐
Rheumatoid disease	☐	☐	☐	☐	☐
Immune problems	☐	☐	☐	☐	☐

Add any important information if it was not addressed above:

Questionnaire reviewed: _____