Asthma & Allergy Institute Of Michigan
Jeffrey M. Bruner, D.O., P.C. John Frith, D.O. Amanda Thomas MS, PA-C
Pediatric and Adult Allergy & Immunology · Bronchial Asthma
42607 Garfield · Clinton Township, MI 48038 · (586) 286.9010

Allergy Questionnaire

Please bring this completed form with you on your first visit.

Name_____Date_____

Please fill in the blanks and circle other applicable answers, feel free to make any additional comments. Base your answers on your own observations and not on what you have been told by others or what you may know about previous skin tests. Though these questions are rather detailed, the information provided will be of major assistance in helping you. If any question is not clear, leave the answer blank and put a check mark in the left hand margin. All information will be considered confidential.

DO NOT TAKE ANY HAY FEVER OR ASTHMA MEDICATION FOR 4 DAYS PRIOR TO YOUR VISIT TO THE OFFICE, unless you are taking steroids (cortisone), fluticasone (Flovent or Advair) which may be continued. However, if you are too ill to stop your medications, please continue to take them.

Symptoms
(Do you have any of the following? If so, please circle. Place approximate onset by month and year, if known, beside each of the symptoms you circle).

EYES	Itching	Burning	Tearing	Swelling	Redness	Discharge
NOSE	Itching	Runny	Stuffy	Sneezing	Loss of Smell	Discharge
EARS	Itching	Fullness	Popping	Drainage	Frequent Infections	
THROAT	Itching	Postnasal Drip	Mucus in Morning			
CHEST	Wheezing	Tightness	Coughing	Shortness of Breath	Pain	
SKIN	Hives	Eczema				

Circle months when symptoms present:

All Year	January	February	March	April	May	June
	July	August	September	October	November	December

Inhalants:

DUST:

Does exposure to house dust make your symptoms worse? Yes No

What are symptoms? _____

Are your symptoms worse during winter? Yes No

ENVIRONMENTAL SURVEY:
Are your symptoms worse in certain areas of your house? Yes No
If so, where?_____

Type of home_____

Age of house_____years Occupied_____years

Is your house located near a (please circle)

Field Forest Lake River Farm

Type of heating system:	*Do you have:*	
Forced air – gas or oil	Humidifier	Yes No
Hot water	Air conditioning	Yes No
Steam	Electronic air cleaner	Yes No
Space Heater		

Your Bedroom: (Please Circle)

Rug Type	Shag	Short Pile	Throw	None
Mattress Type	Foam Rubber	Feather	Cotton	Age_____
Pillow Type	Foam Rubber	Feather	Dacron	Age_____

Basement: (Please Circle)

None	Dry	Damp	Finished	Unfinished

Musty Smell? Yes No Is there a dehumidifier? Yes No

MOLDS:
Are your symptoms worse after exposure to the following:

Hay	Yes	No	***Cutting Grass***	Yes	No
Barns	Yes	No	***Raking Leaves***	Yes	No
Damp Basements	Yes	No			

DANDERS:
Do you have animals in your home? Yes No If so, what type?_____

Do you have symptoms from any animals? Yes No

If yes, what animals and what symptoms?_____

MISCELLANEOUS:
Do you have symptoms after exposure to the following?

Cosmetics	Yes	No	***Insectisides***	Yes	No
Perfumes	Yes	No	***Paint & Varnish***	Yes	No
Hair Sprays	Yes	No	***Soaps & Detergents***	Yes	No
Chemicals	Yes	No	***Wool***	Yes	No
Newspaper	Yes	No	***Cooking Odors***	Yes	No
Aerosols	Yes	No	***Others Smoking***	Yes	No

PHYSICAL AGENTS:
Are your symptoms affected by the following?

Heat	Worse	Better	No Change	***Temperature Change***	Worse	Better	No Change
Cold	Worse	Better	No Change	***Weather Changes***	Worse	Better	No Change
Drafts	Worse	Better	No Change	***Increased Humidity***	Worse	Better	No Change
Exercise	Worse	Better	No Change	***Air Conditioning***	Worse	Better	No Change

Any flare of symptoms with upper respiratory infections (colds)? Yes No

Are your symptoms worse at work? Yes No

Specific Job:_____

Do you have any hobbies? Yes No

If so, list:_____

Are your symptoms <u>better</u> away from home (vacations, etc.)? Yes No

Are your symptoms <u>worse</u> away from home (vacations, etc.)? Yes No

FOODS:
Do any foods make you worse? Yes No

If so, which ones, and what symptoms are produced? _____

_____

Have any special allergy diets been tried in the past? Yes No

Type of diet and conclusions reached? _____

Do you have symptoms from eating (please circle) Cheese Mushrooms Beer Wine

Do you have symptoms from eating melons? Yes No

RASHES from contactants:

Poison Ivy	Yes	Never	***Clothing***	Yes	Never
Poison Sumac	Yes	Never	***Metals***	Yes	Never
Poison Oak	Yes	Never	***Hobbies***	Yes	Never
Other Plants	Yes	Never	***Household Agents***	Yes	Never
Work	Yes	Never	***Adhesive Tapes***	Yes	Never
Ointments	Yes	Never	***Soap***	Yes	Never
Cosmetics	Yes	Never	***Latex***	Yes	Never

Have you ever had hives? **Yes** **No**

If so, what was the cause, if known? _____

Have you ever had any reactions to medications? **Yes** **No**
If yes, please list medications and type of reaction _____

_____

Have you ever had any reactions to insect stings or bites? **Yes** **No**
If yes, what insect and type of reaction _____

_____

IMMUNIZATIONS:
(Please circle appropriate answer and check off in right hand margin if given in past year.)

DPT	Received	Adverse Reaction	
Polio	Received	Adverse Reaction	
Small Pox	Received	Adverse Reaction	
Measles	Received	Adverse Reaction	
Influenza (Flu)	Received	Adverse Reaction	
Mumps	Received	Adverse Reaction	
Tetanus	Received	Adverse Reaction	
Horse Serum	Received	Adverse Reaction	
Blood Transfusions	Received	Adverse Reaction	
Gamma Globulin	Received	Adverse Reaction	

HABITS: (Fill in the blanks)
Average hours of sleep per night_____

Smoker/Non-Smoker Packs per day_____ Cigars per day_____ Years smoking_____

Drink/Do not drink Bottles of beer per week_____ Glasses of wine per week_____
Other alcoholic beverages per week_____

SYSTEM REVIEW:
Do you now, or have you had: (Please Circle)

GENERAL			**HEAD**		
Fatigue	Yes	No	*Frequent or severe head aches*	Yes	No
Chills	Yes	No	*Acne*	Yes	No
Fever	Yes	No	*Patchy loss of scalp hair*	Yes	No
Dizziness	Yes	No			
Fainting	Yes	No			
Sweats	Yes	No			
EYES			**EARS**		
Blurred Vision	Yes	No	*Pain*	Yes	No
Double Vision	Yes	No	*Hearing difficulty*	Yes	No
Spots before eyes	Yes	No	*Hearing loss*	Yes	No
Pain behind eyes	Yes	No	*Ringing*	Yes	No
Pain above eyes	Yes	No	*Recurrent infections*	Yes	No
Pain below eyes	Yes	No			
Infected eyes	Yes	No			
Any change in vision	Yes	No			
*Glasses last checked*_____					
NOSE			**THROAT**		
Frequent colds	Yes	No	*Frequently sore*	Yes	No
Mouth breathing	Yes	No	*Voice change*	Yes	No
Recurrent Sinusitis	Yes	No	*Difficulty swallowing*	Yes	No
Loss of smell	Yes	No	*Frequent infections*	Yes	No
CHEST					
Coughing up blood	Yes	No			
Recurrent pneumonia	Yes	No			
Night sweats	Yes	No			
Shortness of breath when…					
Walking several blocks	Yes	No			
Walking one flight of stairs	Yes	No			
Lying down	Yes	No			
Aware of heart beating	Yes	No			
GASTROINTESTINAL					
Appetite: Excessive Good Fair Poor					
Weight: Gain Loss How much?	____				
Nausea	Yes	No	*Blood in vomitus*	Yes	No
Vomiting	Yes	No	*Recurrent belching*	Yes	No
Diarrhea	Yes	No	*Recurrent abdominal pain*	Yes	No
Constipation	Yes	No	*Fatty stool*	Yes	No
Blood in stool	Yes	No	*Worms*	Yes	No
GENITO-URINARY			**BONES & JOINTS**		
Difficulty passing urine	Yes	No	*Swelling*	Yes	No
Pain on passing urine	Yes	No	*Deformity*	Yes	No
Frequently passing urine	Yes	No	*Arthritis*	Yes	No
Inability to hold urine	Yes	No	*Varicose veins*	Yes	No
Blood in urine	Yes	No	*Phlebitis*	Yes	No
			Neuritis	Yes	No
			Swelling of feet	Yes	No

FAMILY HISTORY and PAST MEDICAL HISTORY:

Have you or has anyone in your family (grandparents, mother, father, sisters, brothers, sons, daughters, aunts or uncles) had: (Please Circle)

			WHO?				WHO?
Anemia	Yes	No		***Polio***	Yes	No	
Asthma	Yes	No		***Severe reactions to insect bites***	Yes	No	
Cancer	Yes	No		***Typhoid***	Yes	No	
Diabetes (sugar)	Yes	No		***Mumps***	Yes	No	
Epilepsy	Yes	No		***Cystic Fibrosis***	Yes	No	
Glaucoma	Yes	No		***Chicken Pox***	Yes	No	
Gout	Yes	No		***Scarlet Fever***	Yes	No	
Hay fever or other nasal allergy	Yes	No		***Allergic Skin Rashes***	Yes	No	
Heart Trouble	Yes	No		***Gonorrhea***	Yes	No	
High Blood Pressure	Yes	No		***Liver disease***	Yes	No	
Hives	Yes	No		***Angiodema***	Yes	No	
Immune Deficiency	Yes	No		***Other Health Problems***	Yes	No	
Kidney or bladder trouble	Yes	No		***Syphilis***	Yes	No	
Migrane	Yes	No		***Arthritis***	Yes	No	
Mononucleosis	Yes	No		***Jaundice***	Yes	No	
Nervous breakdown	Yes	No		***German measles***	Yes	No	
Pulmonary Embolism	Yes	No		***Other serious illness***	Yes	No	
Seizures	Yes	No		***Measles***	Yes	No	
Stroke	Yes	No		***Rheumatic fever***	Yes	No	
Thyroid problem	Yes	No		***Diphtheria***	Yes	No	
Tuberculosis	Yes	No		***Pneumonia***	Yes	No	

List any operations you have had, and the year performed:

_____

List any other hospitalizations and year:

_____

List any conditions for which you are currently being evaluated or treated:

_____

WOMEN ONLY – Menstrual History

Age of onset_____ Date last period started_____Difficulties w/ periods? Yes No

Are you on Birth Control Pills? Yes No Number of pregnancies _____ Number of children _____

Were any illnesses or allergic symptoms made worse or better during pregnancy? Yes No

If yes, describe_____

_____

Is there any other pertinent information about exposure to environmental allergens that you can give us?

_____

_____

Please list all medications you are presently taking:

_____

_____

PLEASE BRING THIS FORM WITH YOU TO THE OFFICE AS WELL AS ALL THE MEDICATIONS YOU HAVE BEEN TAKING. REMEMBER, DO NOT TAKE ANY ALLERGY OR COLD MEDICATIONS FOR ***4 DAYS*** PRIOR TO YOUR VISIT. THANK YOU.

Please Sign_____