Northwest ENT
and Allergy Center

# PATIENT ALLERGY QUESTIONNAIRE

Patient Name: _____ Date: _____

Date of Birth: _____ EMR # _____

Please check the boxes that apply:

1. Does your nose feel……

| | Never | Sometimes | Seasonally | Constantly |
|---|---|---|---|---|
| Stuffy | | | | |
| Runny | | | | |
| Itchy | | | | |
| Post-Nasal Drip | | | | |

2. Do your Ears feel…….

| | Never | Sometimes | Seasonally | Constantly |
|---|---|---|---|---|
| Stopped Up | | | | |
| Itchy | | | | |
| Sore | | | | |
| It Discharges | | | | |

3. Do you have Nasal Blockage…..

| | Never | Sometimes | Seasonally | Constantly |
|---|---|---|---|---|
| Alternating Sides | | | | |
| Constant | | | | |
| Daytime | | | | |
| Nighttime | | | | |
| All Year Round | | | | |
| Seasonal (Check all that apply) | ___ Winter | ___Spring | ___Summer | ___Fall |

4. Do your Eyes……

| | Never | Sometimes | Seasonally | Constantly |
|---|---|---|---|---|
| Water | | | | |
| Itchy | | | | |
| Swollen | | | | |
| Burn | | | | |

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5. Do you sneeze frequently?

| | Never | Sometimes | Seasonally | Constantly |
|---|---|---|---|---|
| Year Round | | | | |
| Seasonally | | | | |
| Daytime | | | | |
| Nighttime | | | | |

6. Do you cough?

| | Never | Sometimes | Seasonally | Constantly |
|---|---|---|---|---|
| Year Round | | | | |
| Seasonally | | | | |
| Daytime | | | | |
| Nighttime | | | | |

7. During what Months do you have the above symptom? (Check all that apply)

| | | | |
|---|---|---|---|
| ___ January | ___ April | ___ July | ___ October |
| ___ February | ___ May | ___ August | ___ November |
| ___ March | ___ June | ___ September | ___ December |

8. Which month do find these symptoms most severe? (Check all that apply)

| | | | |
|---|---|---|---|
| ___ January | ___ April | ___ July | ___ October |
| ___ February | ___ May | ___ August | ___ November |
| ___ March | ___ June | ___ September | ___ December |

9. How many colds do you usually have per year? _____

10. Have you ever smoked? If yes, please answer the following questions:
    a. How many cigarettes per day? _____
    b. How many cigars per day? _____
    c. How many times a day do you smoke a pipe? _____
    d. How many years have you been smoking? _____
    e. If you quit, when did you quit smoking? _____

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11. Do you have any pets or are exposed to pets on a regular basis? ___ Yes ___ No
    a. _____ Cats, How Many? _____
    b. _____ Dogs, How Many? _____

12. Do you have any extreme reactions to insect bites? (Check all that apply)

    _____ Bees
    _____ Wasps
    _____ Spiders
    _____ Snakes
    _____ Ants
    _____ Other _____

    a. Have you been hospitalized for this reaction? _____ Yes _____ No

13. What type of dwelling do you live in and where is it located?

    _____ Single House
    _____ Duplex
    _____ Apartment
    _____ Trailer Home

    _____ City
    _____ Suburban
    _____ Rural
    _____ Farm

14. What prescription and non-prescription medications do you take on a regular basis?

    _____
    _____
    _____

15. What medications relieve your allergy symptoms?

    _____
    _____
    _____

16. Please use the space provided below to tell us anything you would like us to know about your allergy problems.

    _____
    _____
    _____