VIPS

VALLEY INTENSIVISTS, PULMONOLOGISTS AND SLEEP SPECIALISTS

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ALLERGY QUESTIONAIRE

First Name: _____ Last Name: _____
Date of Birth (MM/DD/YY): _____
Do you believe you have allergies: YES _____ NO _____

Have you ever had any of the following problems or symptoms?
Check all that apply:

- Hives or Swelling – How often? _____
- Breathing problems, wheezing, or coughing, with exercise? _____
- Have you been diagnosed with asthma? _____ At what age? _____
  Is your asthma: Severe _____ Moderate _____ Mild _____
- Foul smelling odor in nose? Describe_____
- Skin problems, eczema, or other rases? Describe _____
- Sinus trouble – Hay Fever? _____
- Runny, stuffy, itchy nose – How often? _____
- Any nasal bleeding – How often? _____
- Sneezing – How often? _____
- Frequent cough and/or clearing of throat? _____ How often? _____
- Any hoarseness and/or loss of voice? _____ How often? _____
- Any vomiting? _____ How often? _____
  With what or when do you notice the problem occur? _____
- Itchiness in the ears/throat? _____ How often? _____
- Watery or itchy eyes? _____ How often? _____
- Frequent infections? _____ How often? _____
- Food reaction – Describe _____
- Drug reaction – Describe _____
- Insect reaction – Describe _____

Do you or have you ever taken any medication for the above symptoms? YES _____NO _____
Have you ever had an allergy skin test? YES _____ NO _____
If yes, Date: _____ Physician Name: _____

Were you prescribed medications for allergies? YES _____ NO _____
If yes, specify: _____
Do you take any over the counter allergy medication (e.g., Claritin) YES _____ NO _____
Have you ever had allergy shots? YES _____ NO _____
If yes, when? _____

OFFICE USE ONLY:
Reviewed By: _____ Blood Test Today: YES _____ NO _____