Clarity ENT
Allergy Questionnaire

Name:_____ DOB: _____ Date: _____

Check Boxes and/or Circle Items Which Relate to your Symptoms:

Past Medical History:
- ☐ Any Surgeries/Hospitalizations
- ☐ ER visits for Asthma
- ☐ ER visits for Allergic Reactions
- ☐ ER visits OTHER
- ☐ Any prior serious illness

Social History:
- ☐ Outdoor sports/ recreation
- ☐ Gardening/ Yard work
- ☐ Painting/ Woodworking
- ☐ Arts and Crafts

Work Environment:
- ☐ Office Worker
- ☐ Outdoor worker
- ☐ Work from home/ Stay at home parent
- ☐ Other:_____

Smoking History:
- ☐ Never smoked
- ☐ Former smoker
- ☐ Smoke Cigarettes
- ☐ Cigars/ Pipe
- ☐ Second Hand Smoke

Environment History:
- ☐ City/ Country
- ☐ Private Residence/ Apartment
- ☐ Pets: Dog or Cat or Other
- ☐ Flooring: Carpet, Wood, Tile
- ☐ Pillows: Feather, Synthetic
- ☐ Mattress: Water, Standard, Tempurpedic
- ☐ Do not use pillowcases

Heat and Air Conditioning:
- ☐ Central Heat
- ☐ Space heaters
- ☐ Fireplace
- ☐ Central AC unit
- ☐ AC Units

Nasal Symptoms:
- ☐ Sneezing
- ☐ Runny Nose
- ☐ Thick or yellow nasal discharge
- ☐ Changes with seasons or environment
- ☐ Nose Bleeds
- ☐ Mouth Breathing
- ☐ Snoring

Sinus Symptoms:
- ☐ Sinus pressure/pain
- ☐ Headaches
- ☐ Present on awakening
- ☐ Worse with change of weather

Eye Symptoms:
- ☐ Itchy
- ☐ Watery
- ☐ Swollen
- ☐ Dry

Ear Symptoms:
- ☐ Popping
- ☐ Pressure/ Fullness
- ☐ Pain
- ☐ Ringing
- ☐ Recent ear infection
- ☐ Recurrent childhood infections

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Throat Symptoms:

- ☐ Sore Throat
- ☐ Hoarseness
- ☐ Itching/Lump in throat
- ☐ Tightness
- ☐ Throat Clearing
- ☐ Phlegm in throat

Asthma/Lung Symptoms:

- ☐ Wheezing
- ☐ Shortness of breath
- ☐ Cough
- ☐ Chest tightness
- ☐ Difficulty breathing

Skin Symptoms:

- ☐ Itching
- ☐ Dry Skin
- ☐ Rash
- ☐ Cracking/redness

Reactions to Stinging Insects:

- ☐ Bee
- ☐ Wasp
- ☐ Hornet
- ☐ Yellow Jacket
- ☐ Ants
- ☐ Other:

Food Allergy:

- ☐ Peanuts
- ☐ Tree Nuts
- ☐ Eggs
- ☐ Soy
- ☐ Milk
- ☐ Wheat
- ☐ Chocolate
- ☐ Shellfish

Have you had any of the following symptoms from ingested food?

- ☐ Nausea / Vomiting
- ☐ Rash/ Hives
- ☐ Angioedema
- ☐ Anaphylaxis

Please answer the following questions:

1. Rank your top MOST bothersome allergy symptoms:

   A. _____

   B. _____

   C. _____

2. List any family members who have allergies or who are receiving treatment:

_____

_____

_____

_____

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3. Have you had allergy testing in the past? YES/ NO

If yes, how were you tested (Circle one): Blood test or Skin Testing

4. Are you currently or have you ever received allergy shots? YES /NO

If yes, please list start date and end date of shots:_____

Did you feel better when you were receiving allergy shots? YES/ NO

Why did you discontinue allergy shots?_____

5. Any prior life-threatening reaction to insect bites, foods or medications? YES/ NO

6. Do you have ASTHMA or have ever had asthma? YES/ NO

7. Did you have colic as an infant or experience any problems with formula/breast milk? YES/ NO

8. Do you wake up in the middle of the night between 1-5 AM? YES/ NO

9. Do you experience spaciness and poor memory at times? YES/ NO

10. Do you have hyperactivity and mood swings? YES/ NO

If yes, describe a typical event: _____

_____

_____

11. Do you have carpeting in your home? YES/ NO

12. How old is your home? _____

Is your home dusty? YES/ NO

Have there been any recent renovations to your home? YES/ NO

Have you ever had a mold problem? Flooding/Leaking roof? YES/ NO

13. List all indoor pets:_____

Do your allergy symptoms worsen when coming into contact with any animals? YES/ NO

Describe your reaction:_____

_____

14. Do you have skin rashes or eczema? Describe location and frequency:

_____

_____

_____

_____

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15. How often have you been on antibiotics in the past year?

_____

_____

16. Which of the following locations and situations make your symptoms worse?

☐ At home	☐ Dusting/Vacuuming	☐ Perfume
☐ At work	☐ Dog/ Cat	☐ Chlorine
☐ At school	☐ Air conditioning	☐ Milk
☐ Damp Places	☐ Indoor heater	☐ Eggs
☐ Outdoors	☐ Dry weather	☐ Soy
☐ Mowing lawn	☐ Dog/ Cat	☐ Tobacco
☐ Yard work	☐ After rain	☐ OTHER:

17. During which seasons do you feel worse?

☐ Fall	☐ Spring	☐ All
☐ Winter	☐ Summer	

18. Do you crave any foods? YES/ NO

19. Check any symptoms you typically experience after eating:

☐ Cramping	☐ Runny nose	☐ Gas/Bloating
☐ Diarrhea	☐ Nasal blockage	☐ Nausea
☐ Throat clearing	☐ Burping	☐ Fatigue
☐ Headache	☐ Blurry vision	
☐ Coughing	☐ Throat or oral itching	

20. What foods and drinks do you consume at least 3 times per week? Check all that apply:

☐ Bread	☐ Ice cream	☐ Beef
☐ Cookies	☐ Candy	☐ Coffee/ Tea
☐ Chocolate	☐ Apples	☐ Soda
☐ Rice	☐ Yogurt	☐ Diet drinks
☐ Eggs	☐ Fish	☐ Orange juice
☐ Milk	☐ Soy	☐ Wine
☐ Cheese	☐ Peanuts	☐ Bee

21. Circle how your allergy symptoms affect your quality of life in terms of sleep disturbance at night and/or impairment of work performance and/or impairment of social or recreational activities.

Terribly Mostly Often Occasionally Hardly Mildly Not Affected