BECKER
EAR, NOSE & THROAT CENTER

Initial Visit Questionnaire

Allergy-Immunology

Patient Name: ______________________________ Date of Birth: ____________________

Who referred you for allergy evaluation? ______________________________

What is the primary reason for the referral? ______________________________

Have you ever been diagnosed with allergic rhinitis (seasonal allergies)?

- If yes, have you ever had skin or blood testing before? YES ☐ NO ☐
- Have you ever been on allergy shots before? YES ☐ NO ☐
- What triggers your symptoms? (circle all that apply)

Pollens	Grass	Dust	Wind
Fumes	Smoke	Perfume	Cleaning products
Cats	Dogs	Other Animals: ____________	
Vacuuming	Mowing	Exercising	Temperature changes
Illness	Cold weather	Other: ____________	

Have you ever been diagnosed with asthma? YES ☐ NO ☐

- Are you on any asthma medications? YES ☐ NO ☐
- If yes, what asthma medications are you takings? ____________________

Have you ever been diagnosed with atopic dermatitis (eczema)? YES ☐ NO ☐

Have you ever been diagnosed with chronic hives (uticaria) or angioedema? YES ☐ NO ☐

Do you have a history of recurrent infections? (circle all that apply) YES ☐ NO ☐

Ear infections	Pneumonia	Sinus infections
Skin infections	Bone infections	Other: ____________

Have you ever been treated with antibiotics (more than 2 weeks) for sinusitis? YES ☐ NO ☐

Have you ever had an adverse reaction to foods? YES ☐ NO ☐

- Which food? ______________________________
- What happened? ______________________________

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Have you ever had an adverse reaction to a bee, wasp, hornet, or fire ant? YES ☐ NO ☐

When? ____

What happened? ____

Are you allergic to any medications? YES ☐ NO ☐

Medication: ____________________ Reaction: ____________________

Medication: ____________________ Reaction: ____________________

What type of home do you live in? (circle one)

Single Family Home | Townhouse/ Condo | Apartment | Barracks

Do you have the following in your home? (circle all that apply)

Carpet in bedroom	Carpet in living area	Drapes/curtains
Visible mold/mildew	Window AC unit	Central AC/heat
Fire place	HEPA filters	

Do you have any pets (please indicated quantity) or other animal exposures? YES ☐ NO ☐

___ Cats	___ Dogs	___ Birds	___ Other:____________
___ Horses	___ Sheep	___ Cows	___ Goats

Do you have any exposures at home or related to work, hobbies, etc. that concern you (chemicals, fumes, vapors, etc)? YES ☐ NO ☐

Specify: ____

In the last 3 months have you had any of the following signs or symptoms?

Symptom		Symptom	
Fever	YES ☐ NO ☐	Nausea	YES ☐ NO ☐
Chills	YES ☐ NO ☐	Vomiting	YES ☐ NO ☐
Unexpected Weight Loss	YES ☐ NO ☐	Diarrhea	YES ☐ NO ☐
Cough	YES ☐ NO ☐	Skin rash	YES ☐ NO ☐
Wheezing	YES ☐ NO ☐	Trouble with sense of smell	YES ☐ NO ☐
Shortness of breath	YES ☐ NO ☐	Joint redness or swelling	YES ☐ NO ☐
Heartburn	YES ☐ NO ☐	Dizziness	YES ☐ NO ☐
Abdominal Pain	YES ☐ NO ☐	Headaches	YES ☐ NO ☐