CHESHIRE MEDICAL CENTER
DARTMOUTH-HITCHCOCK • KEENE
580-590 Court Street, Keene, NH 03431 (603) 354-5400

(PLEASE COMPLETE PAPER WORK AND BRING WITH TO YOUR APPOINTMENT)

ALLERGY IMMUNOLOGY QUESTIONNAIRE

PROBLEMS: What can we help you with?

1.
2.
3.

EYE / NOSE / MOUTH SYMPTOMS: If none, circle here

- ☐ Itchy / Watery / Red eyes
- ☐ Itchy nose / Sneezing
- ☐ Nasal congestion / Runny nose / Poor sense of smell
- ☐ Post nasal drainage / Throat clearing
- ☐ Itchy / burning mouth and/or lips

How many years have your symptoms been present?
Are they year-round?
Are they getting worse over time?
When do they get worse? Spring / Summer / Fall / Winter / NA
Where are they worse? Home / Work / School / Indoors / Outdoors / Other

Triggers for these symptoms:

☐ Cut grass	☐ Leaves		☐ Hay	☐ Odors	☐ Perfumes
☐ Cleaning agents	☐ Chemicals	☐ Dust	☐ Smoke	☐ Pollution	☐ Cats
☐ Dogs	☐ Horses		☐ Other animal	☐ Latex	
☐ Weather changes	☐ Exercise	☐ Alcohol		☐ Eating	☐ Lady bugs
☐ Medicines (Aspirin, Ibuprofen, Naproxen)				☐ Fresh fruits or vegetables	
☐ Exposures at work	☐ Other:				

What medicines have you tried for these symptoms?

Antihistamines

- ☐ Zyrtec (cetirizine) (with or without D)
- ☐ Claritin (loratadine) / Clarinex (s-loratadine) (with or without D)
- ☐ Allegra (fexofenadine) (with or without D)
- ☐ Benadryl (diphenhydramine)
- ☐ Vistaril / Atarax (hydroxyzine)
- ☐ Periactin / Cyproheptadine
- ☐ Doxepin

Leukotriene Modifiers

- ☐ Singulair (montelukast)
- ☐ Accolate (zafirlukast)
- ☐ Zyflo (zileuton)

Nasal sprays

- ☐ Flonase (fluticasone)
- ☐ Nasacort (triamcinolone)
- ☐ Nasarel (flunisolide)
- ☐ Nasonex (mometasone)
- ☐ Omnaris (ciclesonide)
- ☐ Rhinocort (budesonide)
- ☐ Afrin (oxymetazoline)
- ☐ Astelin (azelastine)
- ☐ Atrovent (ipratropium)
- ☐ Nasalcrom (cromolyn)
- ☐ Saline (salt water)

Eye drops

- ☐ Elestat (epinastine)
- ☐ Optivar (azelastine)
- ☐ Patanol / Pataday (olopatadine)
- ☐ Zatidor (ketotifen)

LUNG SYMPTOMS: If none, circle here

Shortness of breath / Wheeze / Cough / Chest tightness
Waking up at night because of: Shortness of breath / Wheeze / Cough

Have you ever been diagnosed with asthma? ☐Y ☐N
How many years have symptoms been present?
Are they year-round? ☐Y ☐N
Are they getting worse over time? ☐Y ☐N
When do they get worse? Spring / Summer / Fall / Winter / NA
Where are they worse? Home / Work / School / Indoors / Outdoors / Other

Emergency Room:

Have you been there for your symptoms? ☐Y ☐N
If so, how many times?
If so, what did they treat you with?
Epinephrine / Benadryl / Steroids / Breathing treatment / IV fluids Other:
When was the last time you went for your symptoms?

Hospitalizations:

Have you had to stay overnight in the hospital for your symptoms? ☐Y ☐N
If so, how many times?
Have you ever been to the Intensive Care Unit for your symptoms ☐Y ☐N
Have you ever been intubated (had a breathing tube inserted)? ☐Y ☐ N

Steroids:

Have you been treated with steroids (prednisone, methylprednisolone, etc.) for these symptoms?
☐ Y ☐N
If so, how many times?
When was the most recent time?

Triggers for these symptoms:

☐Cut grass	☐Leaves	☐Hay	☐Odors	☐Perfumes
☐Cleaning agents		☐Chemicals	☐Dust	☐Smoke
☐Pollution	☐Exercise	☐Alcohol	☐Cats	☐Dogs
☐Horses	☐Other animal	☐Humidity	☐Weather changes	
☐Heat	☐Cold air	☐Heartburn	☐Infections	☐Foods
☐Anxiety / Stress		☐Lady bugs	☐Latex	

☐Medicines (Aspirin, Ibuprofen, Naproxen)
☐ther:

What medicines have you tried for these symptoms?

Inhalers

☐Albuterol	☐Xopenex (levalbuterol)
☐Maxair (pirbuterol)	☐Flovent (fluticasone)
☐Asmanex (mometasone)	☐Azmacort (triamcinolone)
☐Serevent (salmeterol)	☐Advair (fluticasone / salmeterol)
☐Intal (cromolyn)	☐Symbicort (budesonide / formoterol)
☐Atrovent (ipratropium)	☐Combivent (ipratropium / albuterol)
☐Primatine Mist (epinephrine)	Spiriva (tiotropium)
☐Pulmicort (budesonide)	

Immune modulators

☐Xolair (omalizumab)
☐Steroids (prednisone, methylprednisolone, prednisolone)
☐Other:

SKIN SYMPTOMS: **If none, circle here**

☐ Itchy skin / Rash / Eczema / Hives / Swelling
☐ Other:

Triggers for these symptoms:
☐ Sun exposure ☐ Heat ☐ Cold ☐ Stress ☐ Scratching ☐ Pressure ☐ Vibration
☐ Other:

GASTROINTESTINAL SYMPTOMS: **If none, circle here**
☐ Difficulty Swallowing / Food getting stuck / Heartburn / Acid reflux
☐ Other:

Triggers for these symptoms:

ANAPHYLAXIS (sudden onset life-threatening allergic reaction): **If none, circle here**
Triggers:

OTHER:

TREATMENT

Epinephrine

Has injectible epinephrine (EpiPen / Twinject) been prescribed to you? ☐ Y ☐ N
If so, do you know how to use it ☐ Y ☐ N
Have you had to use it? ☐ Y ☐ N
If yes, how many times ?
If yes, when was the last time?
Did it help? ☐ Y ☐ N
Do you keep it with you at all times?
How many do you have ?

DRUG REACTIONS: **If None – Circle here**

☐ Antibiotics (penicillins / sulfa / azithromycin / erythromycin / etc.)
☐ Non-steroidal medications (aspirin / ibuprofen / naproxen / etc.)
☐ Narcotics (morphine / codeine / etc.)
☐ Local anesthetics (lidocaine / novocaine / etc.)
☐ Other:

Please describe what happened for each drug that caused problems:
1.
2.
3.
4.
5.

FOOD REACTIONS: If none, circle here

☐ Milk
☐ Egg
Peanut
☐ Tree nuts — Almond / walnut / cashew / hazelnut / pecan / brazil nut pistachio / macadamia nut / pine nuts
☐ Soy
☐ Wheat
☐ Shellfish: Clams / Oysters / Scallops / Mussels
☐ Crustaceans: Crabs / Lobster / Shrimp / Crayfish
☐ Fish: Salmon / Tuna / Haddock / Cod
☐ Other seafood: Squid / octopus / eel
☐ Seeds: Sesame / poppy / sunflower
☐ Spices
☐ Fresh fruit
☐ Fresh vegetables
☐ Grains Rice / oats / barley
☐ Breads
☐ Meats: Beef / pork / chicken
☐ Other:

For each food reaction, please describe the symptoms you had:
1.
2.
3.
4.

For each food:
When was the first reaction to this food?
How many times has this happened?
How much of the food did you eat each time?
How soon after eating did the reaction start?
Has this happened each time you ate this food? ☐ Y ☐ N
Have you ever eaten the food and not had this happen? ☐ Y ☐ N
Are the reactions getting worse over time? ☐ Y ☐ N
Have you had to go to the Emergency Room? ☐ Y ☐ N
If so, how many times?
If so, what did they treat you with? Epinephrine / Benadryl / Steroids / Breathing treatment / IV fluids / Other:
Have you had to stay overnight in the hospital for your symptoms? ☐ Y ☐ N

STINGS

Have you been stung by an insect? ☐ Y ☐ N **If No, skip to the bottom of this section**

Have your reactions been: Local (redness / pain / warmth /swelling at the sting site) or Systemic (anything besides local)

If Local reactions only, skip the rest of this section.

Please circle any symptoms you had after being stung:
Itchy / Watery / Red eyes
Itchy nose / Sneezing / Nasal congestion / Runny nose
Post nasal drainage / Throat clearing
Itchy / burning mouth and/or lips
Shortness of breath / Wheeze / Cough / Chest tightness / Chest pain
Itchy skin / Rash / Hives
Swelling of face / eyes / mouth / lips / tongue / throat / hands / feet / other
Difficulty Swallowing / Difficulty Speaking
Heartburn / Acid reflux / Nausea / Vomiting / Diarrhea / Abdominal pain

Lightheadedness / Loss of consciousness

With each sting:
Have you had to go to the Emergency Room? ☐Y ☐N
If so, how many times?
If so, what did they treat you with? Epinephrine / Benadryl / Steroids / Breathing treatment / IV fluids / Other:
Have you had to stay overnight in the hospital for your symptoms? ☐Y ☐N
If so, how many times?
Did you have to go the intensive care unit for this reaction? ☐Y ☐N
Have you been treated with steroids (prednisone, methylprednisolone, etc.) for your symptoms? ☐Y ☐N
If so, how many times?
Has injectible epinephrine (EpiPen / Twinject) been prescribed to you? ☐Y ☐N
If so, do you know how to use it (☐Y☐N) / have you had to use it (☐Y☐N) and how many times / do you keep it with you at all times (☐Y☐N/) / how many do you have ?
Do you have a medic-alert bracelet?

Have you been stung since your most recent serious reaction to a sting?
If so, what happened?

Please describe your reactions for each sting:
1.
2.
3.

ANY OTHER REACTION TO INSECTS?

ANY MEDICAL PROBLEMS (Now or in the past)? If none, circle here

1.
2.
3.
4.
5.
6.
7.
8.
9.
10.

Females:
Have you started your menstrual cycle?
At what age did your menstrual cycle start?
Last menstrual period:
How many times have you been pregnant?
How many live births have you had?
How many (if any) miscarriages?

ANY SURGERIES? If none, circle here

1.
2.
3.

BIRTH HISTORY (for children age 12 years and younger) **Otherwise, circle here**

☐ Problems / complications with the pregnancy?
☐ Born at term / ☐ early / l☐ ate
☐ Vaginal delivery / ☐ C-section
☐ Spontaneous /☐ Induced
☐ Problems / Complications at birth?
☐ Breast-fed or Formula and until what age?
At what age were solids introduced?
Any developmental concerns? If yes, please explain

ALLERGY HISTORY: If none, circle here

Have you seen an allergist before? ☐ Y ☐ N
If so, who, where, and when?
Have you ever had allergy skin / blood testing? ☐ Y ☐ N
If yes, when was the last time?
What were you allergic to?
Have you ever had allergy shots? ☐ Y ☐ N
If yes, for how many years, and when were they started?
Did they help? ☐ Y ☐ N

ANY INFECTIONS? If none, circle here

☐ Brain infections (meningitis, encephalitis)
☐ Eye infections (conjunctivitis, pink eye, etc.)
☐ Ear infections
☐ Sinus infections
☐ Tooth cavities / abscesses
☐ Gum disease (gingivitis)
☐ Mouth infections (thrush, other)
☐ Cold sores
☐ Canker sores
☐ Throat infections (strep throat, tonsillitis, pharyngitis)
☐ Thyroid infections
☐ Lung infections (pneumonia, bronchitis)
☐ Heart infections (pericarditis, endocarditis, infectious cardiomyopathy)
☐ Stomach infections (H. pylori, other)
☐ GI tract infections (bacterial overgrowth, colitis, diarrhea, C. dificile colitis, other)
☐ Liver infections (hepatitis)
☐ Pancreas infections (pancreatitis)
☐ Kidney infections
☐ Bladder infections (cystitis) / urinary tract infections (UTI's)
☐ Pelvic infections (pelvic inflammatory disease, other)
☐ Vaginal yeast infections (only with taking antibiotics / at random)
☐ Genital ulcers
☐ Sexually transmitted diseases (HIV, gonorrhea, Chlamydia, hepatitis C, genital herpes)
☐ Bone infections (osteomyelitis)
☐ Blood stream infections
☐ Skin infections (abscesses, boils, cellulites, Strep, Staph, etc.)
☐ Warts
☐ Poor wound healing
☐ Surgical scars – infection and breaking open after stitches put in
☐ Viral infections (chicken pox, shingles, small pox, mononucleosis, HIV, Herpes, Hepatitis A/B/C, molluscum, measles, German measles, mumps, polio, rabies, fifth's disease [parvovirus])
☐ Other:

Sinus infections: **If none, circle here**
What symptoms do you get?
How many times per year do you get antibiotics for a sinus infection?
How many years has this been happening?
When was the most recent infection?
Have you ever had a sinus CT scan?
If yes, what did it show?

Pneumonia: **If none, circle here**
How many times have you had pneumonia?
How many of those times was the pneumonia seen on a chest X-ray?
How many of those times were you kept in the hospital overnight or longer?
How old were you with the first pneumonia?
When was the most recent pneumonia?

Any infections requiring antibiotics to be given through an IV (through your vein)?

Any infections requiring hospitalization?

MEDICINES THAT AFFECT THE IMMUNE SYSTEM: If none, circle here

Have you taken any medicines that might suppress (weaken) the immune system? ☐Y ☐N
If yes, please list:
Have you had chemotherapy? ☐Y ☐N
Have you had radiation therapy? ☐Y ☐N
Have you taken steroids (prednisone) on a regular basis? ☐Y ☐N
Have you taken any medicines that change the immune system, such as: ☐Y ☐N
☐Rituxan / rituximab ☐Remicade / infliximab Humira / adalimumab
☐Enbrel / etanercept ☐Xolair / omalizumab ☐Other:

FAMILY HISTORY

Does anyone have asthma / hay fever / allergies / atopic dermatitis / eczema? ☐Y ☐N
If so, who?
How many brothers and sisters do you have?
How is their health?

Does anyone have a problem with their immune system?
Does anyone get sick often? ☐Y ☐ N
If so, who?

Does anyone have an autoimmune disease (where the immune system attacks a person's own body)?
Examples of this include: Lupus, scleroderma, multiple sclerosis, thyroid disease, type I diabetes, rheumatoid arthritis, crohn's disease, ulcerative colitis, celiac disease, polymyositis, dermatomyositis, myasthenia gravis

Have any children in the family died from infection? ☐Y ☐N
Has anyone in the family died from an infection?

Is there any consanguinity in the family (people who are related to each other and have had children together)?

Has anyone in the family had cancer? (blood, colon, lung, breast, other)

Please list any other medical problems that run in the family:
1.
2.
3.
4.
5.

SOCIAL HISTORY

Children:
Are you at home, daycare, or school? ☐Y ☐N
If applicable, what grade are you in?

Who do you live with? ☐Y ☐N
Sports / Hobbies / Activities / etc.

Adults:
Are you currently attending school? ☐Y ☐N
If so, what are you studying?

What is your current job?
What are your current job responsibilities (in brief)
What jobs have you had in the past?
Any toxic exposures with any of your jobs?

Have you ever smoked? ☐Y ☐N
If yes, how many packs per day on average, and for how many years total?
Are you a current smoker?

How much alcohol do you drink on a weekly basis?

Any HIV risk factors? (needle sticks, blood transfusions, IV drug use, tattoos, sexual contact with anyone having HIV) ☐Y ☐N

Any travel outside the US?
If yes, where and when?

ENVIRONMENTAL HISTORY

Where do you live? ☐ house / ☐apartment / ☐duplex / ☐mobile home / ☐other
How old is it?
Heat: ☐hot air / ☐radiator / ☐electric baseboard / ☐wood stove
Basement: ☐None / ☐finished / ☐unfinished / ☐dry / ☐damp
Do you have well water or town water?

Pets: ☐None / ☐cat / ☐dog / ☐ rabbit /☐fish / ☐guinea pig / ☐bird / ☐other
If yes, how many of each?

Any problems with☐ladybugs / ☐cockroaches / ☐ mice ? ☐N

Do you live on a farm? ☐Y ☐N
Outdoor animals: ☐None / ☐horse /☐ cow /☐ sheep / ☐chicken / ☐goat / ☐other

Bedroom flooring: ☐Hardwood / ☐carpet / ☐area rug
Bed type: ☐box spring and mattress / ☐waterbed / ☐futon / ☐foam /☐other
Bedroom: ☐Curtains /☐Drapes / ☐blinds / ☐stuffed animals

Does anyone smoke at home (indoors or outdoors)? ☐Y ☐N
Who?
Do you have any other exposure to tobacco smoke?