Conder Medical & Dental Centre

NEW PATIENT ALLERGY QUESTIONNAIRE

Name _____ Age _____ Sex ☐ M ☐ F

Occupation _____ Date _____

Current history

Symptoms (please tick)

NOSE
- ☐ *blocked*
- ☐ *sneezing*
- ☐ *itchy*
- ☐ *sniffles*
- ☐ *nasal discharge*
- ☐ *loss of smell*
- ☐ *frequent nosebleeds*
- ☐ *none*

EARS
- ☐ *itching*
- ☐ *popping*
- ☐ *congested/ blocked*
- ☐ *none*

EYES
- ☐ *itchy*
- ☐ *watery*
- ☐ *redness*
- ☐ *swelling*
- ☐ *dark circles*
- ☐ *conjunctivitis*
- ☐ *none*

MOUTH/THROAT
- ☐ *mouth breathing*
- ☐ *itchy palate*
- ☐ *itchy throat*
- ☐ *post nasal drip*
- ☐ *frequent sore throat*
- ☐ *none*

ASTHMA/CHEST
- ☐ *wheezing*
- ☐ *chronic cough*
- ☐ *shortness of breath*
- ☐ *chest tightens*
- ☐ *sputum*
- ☐ *none*

How long have you had your symptoms? _____

Are your symptoms (Choose one)

Perennial ☐ (Present all year round but worse at certain times.)

Seasonal ☐ (Only at certain times of the year e.g. spring.)

Random ☐ (Coming and going without any relation to time of year.)

Comments: _____

Circle the months when your symptoms are worse:

JAN FEB MAR APR MAY JUN JUL AUG SEP OCT NOV DEC

How long do your symptoms last?

More than 4 days per week ☐ Yes ☐ No More than 4 weeks in a row ☐ Yes ☐ No

Are your symptoms worse (circle):

Indoors Outdoors At home At Work At School Mornings Evenings

	No	Occasionally	Frequently	Comments
Do your symptoms restrict your leisure/sport activities?	☐	☐	☐	_____
Do you miss school/work because of your symptoms?	☐	☐	☐	_____
Do your symptoms disturb your sleep?	☐	☐	☐	_____

Have you been diagnosed with Asthma? ☐ Yes ☐ No

What medications have you used to treat your allergy symptoms, including nasal sprays?

Type	Oral H1-antihistamine	Nasal H1-antihistamine	Anti-allergy eye drops	Nasal corticosteroid	Other
Frequency					

List all other medications you are currently taking: _____

Past/family history

At what age did you first have an allergic reaction? ☐ 0-1yrs ☐ 1-5yrs ☐ 15-25yrs ☐ 25+yrs

What was your first allergic condition? (circle)

Hay fever Asthma Eczema Food allergy Insect bite Acute allergic reaction

Is your first allergic condition still your main problem? ☐ Yes ☐ No

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How often did you have colds, sinusitis, upper respiratory infection, hay fever? _____

Have you ever been skin tested or had a blood test for allergies? ☐ Yes ☐ No

If yes, what year _____ what were the results _____

Has any member of your family had any of the following?

Condition/Relative	Mother	Father	Sister(s)	Brother(s)	Grandparents
Asthma					
Hay Fever					

Home/work/environment

Do you live in (please circle) house unit caravan farm other _____ city country
Is your home air conditioned? ☐ Yes ☐ No if Yes (circle) ducted/central fan
Is your home heated? ☐ Yes ☐ No if Yes (circle) ducted/central fireplace gas electric other
Do you spend much time in air conditioned places? ☐ Yes ☐ No if Yes (circle) home work
Your bedroom has (circle): plants * stuffed toys * carpet * rugs * bookshelves * humidifier * doona * drapes pillows-(feather/foam/synthetic) * blinds-(fabric/wood/other)
Your house has (circle): plants * stuffed toys * carpet * rugs * drapes * blinds-(fabric/wood/other) * bookshelves humidifier * chair coverings-(cloth/leather) * Sofa/lounge-(cloth/leather) cushions-(feather/foam/synthetic)
Your workplace (circle): air conditioning * heating * carpet * rugs * blinds-(material/wood) * plants chair coverings-(cloth/leather)
How old is your? mattress _____ pillow _____

Do you have the same symptoms when travelling or away from home? ☐ Yes ☐ No
If no, is there any place/environment where you do not suffer from your symptoms? _____

What pets/animals do you have at home or in the workplace? Dog Horse Cat Other_____ None
Do the pets/animals spend time indoors at your home or workplace? ☐ Yes ☐ No
How long have you had pets? _____
List other pets/animals you are in contact with _____

Doctors use only

SEASONAL PERENNIAL
(Please circle most relevant)

Sleep	Y	N
Leisure/Sport activities	Y	N
Work/School	Y	N
Troublesome symptoms	Y	N

Diagnosis _____

ELIGIBLE FOR PROCEDURE Y N
PATIENT CONSENT
HT WT BP
PREDICTED P/F ACTUAL P/F

INTERMITTENT symptoms
- < 4 days per week
- and < 4 weeks

PERSISTENT symptoms
- > 4 days/week
- and > 4 weeks

MILD
- normal sleep
- normal daily activities, sport, leisure
- normal work and school
- no troublesome symptoms

MODERATE-SEVERE
one or more items
- abnormal sleep
- impairment of daily activities, sport, leisure
- problems caused at work or school
- troublesome symptoms

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