DEBORAH J. FREEHLING, M.D., INC.

Board Certified

Ear Nose & Throat · Allergy · Head & Neck Surgery · Facial Plastic Surgery

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ALLERGY HISTORY QUESTIONNAIRE

Name _____ Referred by _____ Date _____

Address _____

Telephone (H) _____ (W) _____ Employer _____

Birthday _____ Age _____ Marital Status _____

Insurance Information: Name of Insured _____

Employer of Insured _____

Insurance Company _____ Insurance ID# _____

Please study carefully each question and answer it as best as you can:

Cough? Constant _____ Intermittent _____ Daytime _____ Nighttime _____

Frequent colds or Upper Respiratory Infections? _____ As a child? _____

Temperature with colds? _____

Sneezing? _____ What might precipitate it or increase it? _____

Is it seasonal or related to location? _____

Sore Throats? Frequency? _____
From infections? Yes _____ No _____
From drainage? Yes _____ No _____

Nose Drainage? From the front or down the throat? Circle one.
Drainage clear or colored? Thick? _____ Thin? _____ From right side _____
From left side? _____ Both _____

Nose Blockage? Right side? _____ Left side? _____ Both? _____

Eye Symptoms? Burning? Watering? Puffy? Circle one
Itching? Yes _____ No_____ Where? Inside corner _____ Outside _____
All over? _____

Headaches? Which part of the head? _____. What starts a headache? _____.

What makes it worse? _____ Is headache worse at any certain time of day? _____.

Can you tell when a headache may be starting? _____ How? _____.

Fatigue? _____ When? _____ Certain times of the day? _____

Before eating? _____ After? _____ Certain days of the week? _____

When? _____ Chronic? _____

Shortness of breath? _____ Do you know why? _____

Explain _____

Wheezing? _____ Now? _____ As a child? _____ With exercise? _____

Out in the cold? _____ With infections? _____ Other things the may cause your

wheezing? _____

Asthma? _____ Now? _____ As a child? _____

As a child did you have frequent urinary tract infections? _____

Do you have “sinus problems”? _____

Earaches? _____ Do your ears drain or run? _____ If so, clear or cloudy drainage? _____

Do you experience any of the following sounds or sensations? Itchy? _____ Stuffy? _____

Flaky? _____ Ring? _____ Buzz? _____ Crackle? _____ Pop? _____ Other sounds? _____

Hearing loss? _____ Vertigo (Spinning)? _____ When? _____

Loss of smell? _____ When? _____

Loss of taste? _____ When? _____

Laryngitis? _____

Eczema? _____ Now? ____ As a child? _____ Describe type and location _____

Hives? _____ When? _____ Where? _____ Specify? _____

_____ Any known material the causes a rash? _____

Soap? _____ Ointments? _____ Paints? _____ Clothing? _____ Cosmetics? _____

Poison Ivy? _____ Fungus infections? _____ Athletes foot? _____ Vaginitis? _____

Jock rash? _____

Do you currently have premenstrual syndrome (female)? _____

Do you have acne? _____

Have you ever been diagnosed as having ENDOMETRIOSIS (female)? _____

Pets? _____ Kind? _____ Keep inside or out? _____ Breed? _____

How long have you had your pet? _____ Symptoms worse when visiting friends who have pets? _____ Animal contact that causes symptoms? _____

Do you smoke? _____ Cigarettes? _____ Cigars? _____ Pipe? _____ Snuff? _____

Chew tobacco? _____

If you do not smoke, does someone else's smoke bother you? _____

Do you perspire excessively? _____

Do you regard yourself as being nervous? _____

Problem with personality or behavioral changes? _____ Certain times of the day? _____

Explain _____

Certain seasons? _____ With certain foods? _____

Itchiness? _____ Nose? _____ Roof of mouth? _____ Ears? _____

Hands? _____ Feet? _____

Were you a premature baby? _____ As an infant, were you taken off formula or any foods? ___ _____ Specify _____

Were you a colicky of fussy baby? _____ Breast or Bottle fed? _____

Have you ever experienced anxiety or panic attacks? _____ Are you being treated? _____

Do you suspect any food of increasing your symptoms? _____ Specify? _____

Do you have any specific cravings or do you overindulge in certain foods? _____

List: _____

Does any certain food give you indigestion, hives, otherwise upset you? _____ Specify? _____

_____ Do you have irritable bowel? _____

Do you have excess gas without eating gaseous foods, such as fiber, beans, cabbage, etc.? _____

Are you awakened during the night with any symptoms? _____ Which Symptoms?

Headaches? _____ Bloating? _____ Dizziness? _____ Thirst? _____

Stomach cramps? _____ Heartburn? _____ Dry cough? _____ Sore throat? _____

Do you awaken in the morning with any symptoms? Joint pain/stiffness? _____

Increased congestion? _____ Increased drainage? _____ Nausea? _____

Other? _____

Do your symptoms increase or decrease with the following conditions:

INCREASE	**DECREASE**	**SAME**	
_____	_____	_____	Cold weather
_____	_____	_____	Warm Weather
_____	_____	_____	Air Conditioning
_____	_____	_____	Windy Days
_____	_____	_____	March to May
_____	_____	_____	May to July
_____	_____	_____	August to October
_____	_____	_____	November to March
_____	_____	_____	Damp Weather
_____	_____	_____	Housework (dusting, etc.)
_____	_____	_____	High pollution levels
_____	_____	_____	Change of seasons
_____	_____	_____	When furnace goes on
_____	_____	_____	Going to bed
_____	_____	_____	After asleep for a short time

INCREASE	**DECREASE**	**SAME**	
_____	_____	_____	Upon rising
_____	_____	_____	Later in the day, 4-9 pm
_____	_____	_____	Being in or mowing grass

HOME AND WORK ENVIRONMENT

(Please Specify by H for Home and W for Work)

What is your occupation? _____

Do you participate in any particular activities, hobbies, or recreation? _____ Please specify:

_____.

Are your symptoms increased at home, work or no change? _____

Are you exposed to excessive amounts of dusts, fumes, chemicals, noise? _____

Are there plants, dried flowers, fresh flowers at home or work? _____

HEATING SYSTEM: (HOME AND WORK)

Electric _____ Gas _____ Oil _____ Propane _____ Kerosene heater _____

Forced air _____ Hot water _____ Fireplace _____ Wood burning stove _____

Coal burning stove _____ Air conditioning _____ Air cleaner _____ Humidifier _____

COOKING: Gas _____ Electric _____ Propane _____

LAUNDRY: Do you use softener sheets, liquid softener, or bleach in the laundry? Circle one

COSMETICS: Do you use makeup? _____ Eye make up? _____ Perfume? _____

Aftershave? _____

HOUSING:

Do you live in a house? _____ Two story? _____ Split level? _____ Ranch? _____

Trailer? _____

Do you live in an apartment? _____ Small building? _____ Large building? _____

Older building? _____ Newer building? _____

Have you had insulation blown into your house? _____

FURNITURE:

Upholstered? _____ Not upholstered? _____

Fabric? _____ Vinyl? _____ Other? (What)? _____

FLOOR COVERINGS:

_____ Carpeting and pads

_____ Carpets and pads

_____ Rugs and pads

_____ Throw rugs

_____ Linoleum

WALL COVERINGS:

_____ Wall paper

_____ Fabric

_____ Paneling

_____ Tapestries

_____ Pennants

MATTRESS:

_____ Innerspring

_____ Waterbed

_____ Foam rubber

_____ Other (specify)

_____

WINDOW COVERINGS:

_____ Washable curtains/drapes

_____ Unwashaable curtains/drapes

_____ Shades

_____ Blinds

_____ Others

BEDS AND BEDDING:

_____ Number of beds

_____ Comforters

_____ Chenille bedspread

_____ Stuffed animals

PILLOWS:

_____ Feather or down

_____ Foam rubber

_____ Kapok

_____ Dacron or polyester

Do your symptoms improve, get worse or stay the same when on vacation? Circle one.

Where do you usually go on vacation? Mountains, Seashore, other _____

FAMILY HISTORY:

	FATHER	MOTHER	BROTHER	SISTER	CHILD
Bronchial Asthma	_____	_____	_____	_____	_____

	FATHER	MOTHER	BROTHER	SISTER	CHILD
Emphysema	_____	_____	_____	_____	_____
Hay Fever	_____	_____	_____	_____	_____
Sinus Problems	_____	_____	_____	_____	_____
Hives	_____	_____	_____	_____	_____
Postnasal	_____	_____	_____	_____	_____
Drainage	_____	_____	_____	_____	_____
Eczema	_____	_____	_____	_____	_____
Thyroid Problems	_____	_____	_____	_____	_____
Food Allergies	_____	_____	_____	_____	_____

How long have you had specific symptoms that brought you to our office? Years _____

Months _____ Weeks _____ Days _____

Have you had allergy testing before? _____

Doctor who performed the tests: _____ Address: _____

Date of last testing: _____ Type of testing: Scratch, Intradermal, RAST (circle one)

Were there positive reactions? _____ To what? _____

Were you treated? _____ For What? _____

With injection? _____ Medication? _____ Other treatment? _____

How long? _____ Did you improve with treatment? _____

MEDICAL HISTORY

Present illness or symptoms: _____

Illnesses treated for in the past 5 years: _____

LIST ALL MEDICATIONS YOU ARE TAKING NOW: _____

_____.

List any allergies to any medications: _____

List all operations you have had: _____

When was your last chest x-ray? _____ Result? _____

When was your last EKG? _____ Result? _____

When was your last stress EKG? _____Result? _____

Have you ever had? (check) if yes

( ) Head injury	( ) Liver disease	( ) Major injuries
( ) Cancer (of _____)	( ) Eye problems	( ) Diabetes
( ) Lung/Breathing problems	( ) Thyroid problems	( ) Coughing up blood
( ) Kidney or urinary problems	( ) Heart/Circulatory problems	( ) Arthritis
( ) High blood pressure	( ) Epilepsy or seizures	( ) Stomach or intestinal problems
( ) Emotional problems	( ) Easy bruising	( ) Bleeding or Blood problems
( ) Gallbladder problems	( ) Vomiting or passing blood in stools	

Explain all YES answers and describe any other problems: _____

_____

_____

Have you had any steroids (cortisone) in the past month? _____