The Everett Clinic
For the whole you.
3901 Hoyt Avenue ■ Everett, WA 98201 ■ 425-259-0966

NAME: First Middle Last

____

Date of Birth ____________ Age _____

Today's Date ____________

ALLERGY CLINIC – PATIENT QUESTIONNAIRE

Who sent you here? ______________________________
Who is your regular family doctor? ______________________________
What is your main problem? ______________________________
When did you first have it? ______________________________

Symptoms: Please check any symptoms that you have. Use "?" if unsure.

Eyes:
___ itchy
___ redness
___ watery
___ swollen
___ discharge

Nose:
___ itchy
___ sneezing
___ runny
___ stuffy
___ snoring
___ decreased smell/ taste

Ears:
___ plugging
___ decreased hearing
___ pain
___ ringing

Mouth/Throat:
___ throat clearing
___ hoarseness
___ sore throat

Lungs:
___ cough
___ shortness of breath
___ chest tightness
___ Wheezing

Gastrointestinal:
___ heartburn / indigestion
___ abdominal pain
___ bloating

Skin:
___ hives / rash
___ itchy skin
___ eczema

Other:
___ fatigue
___ fever
___ headache

Triggers: What makes your symptoms occur? Check & circle all that apply.

___ cats / dogs / animals
___ feathers
___ house dust
___ mold / dampness

___ flowers / grass / trees
___ exercise
___ smoke
___ strong odors

___ insect stings
___ medications (list)
___ foods (list)
___ other (list)

Seasonality:
What time of the year do you have symptoms? ______________________________
Which months are best? ____________ Which months are worse? ____________

Previous Allergic Workup, Skin Tests &/or Shots ______________________________
____

Environmental History:
How long have you lived in the Northwest? ____________ Where did you live before? ____________

Dwelling:
age____
Carpeting: age____
Type of heating ________
____ House
____ Apartment
____ Mobile Home

Mattress:
age____
____ Waterbed
____ Foam / Innerspring

Pillow:
age____
____ Down / Feathers
____ Foam

Pets
___ cat (indoor/ outdoor)
___ dog (indoor/ outdoor)
___ other (list)

PLEASE ANSWER BOTH SIDES OF THE QUESTIONNAIRE

DO NOT FILE
19-014 2/09

Social History:

Occupation (if have one) or Grade in School: _______________

Unusual exposures at work or school: _________________

Smoking: Current _______ packs per day x _____ years

Previous _______ packs per day x _____ years

Any smokers in household? No / Yes Who? ___________ How much? __________ Where? ___________

Family history: Please check off any family members that have the following problems:

Allergies of the eyes / nose:	☐ mom	☐ dad	☐ brother	☐ sister	☐ child(ren)
Asthma:	☐ mom	☐ dad	☐ brother	☐ sister	☐ child(ren)
Eczema:	☐ mom	☐ dad	☐ brother	☐ sister	☐ child(ren)
Food allergies:	☐ mom	☐ dad	☐ brother	☐ sister	☐ child(ren)
Immune problems:	☐ mom	☐ dad	☐ brother	☐ sister	☐ child(ren)

Adopted: ☐

Please circle any ongoing problems that you currently have:

General Health: fever or chills / fatigue / weight loss / weakness

Mental Health: memory problems / depressions / stress / anxiety

Neurological: fainting / poor balance

Endocrine: swollen glands / hot or cold intolerance

Ear/Nose/Throat: hearing problems / eye sight problems / dental problems

Respiratory: cough / shortness of breath / chest tightness / wheezing

Heart: chest pain or pressure / irregular heart beat / leg pain with walking

Digestive: swallowing trouble / indigestion / abdominal pain / constipation / diarrhea / blood in stools

Urinary: leaking bladder / difficulty urinating

Reproductive: vaginal or urethral discharge / hot flashes

Skin: rash / skin problem

Past Medical History: You may leave this section blank IF your primary care physician is an Everett Clinic doctor.

Major medical illnesses: ____

____

Surgeries: ____

____

Hospitalizations: ____

Immunization status (children only): _________________________________

Current Medications:

Prescription | Over the Counter

Medication Allergies: ____

NAME and LOCATION of your preferred pharmacy: ___________________________