CUMBERLAND VALLEY ENT CONSULTANTS/ALLERGY DEPARTMENT

ALLERGY QUESTIONNAIRE

Patient's Name:_____Date:_____

Do you have any of the following:

Nasal Congestion	Y	N	Frequent Sneezing	Y	N
Watery Nasal Discharge	Y	N	Discolored Nasal Drainage	Y	N
Sinus/Facial Pain	Y	N	Itchy Nose/Throat	Y	N
Itchy, Burning Eyes	Y	N	Post Nasal Drip	Y	N
Chronic Headaches	Y	N	Asthma	Y	N
Chronic Cough	Y	N	Shortness of Breath	Y	N
Wheezing	Y	N	Eczema	Y	N

When did symptoms begin?_____
Do you have a family history of allergy?_____
Circle which season or seasons are most difficult for you: SUMMER FALL WINTER SPRING

ENVIRONMENT:

How old is your home?_____

Do you have a basement?	Y	N
Is your basement damp or does it have a musty smell?	Y	N
Do you have standing water or leaks in or around your home?	Y	N
Do you have carpet in your bedroom?	Y	N

Please list indoor pets:_____
What type of work do you do?_____

PLEASE ANSWER THE FOLLOWING QUESTIONS IF PATIENT IS A CHILD:

Was the patient premature or full term? (Circle one)
Was the patient breast or bottle fed? (Circle one)

Was the patient a colicky baby?	Y	N
Is the patient in daycare?	Y	N
Does anyone smoke around the patient?	Y	N