

# AIM Allergy Questionnaire (revised 2-08)

## Personal/Family Medical History:

Patient Name: \_\_\_\_\_ age \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Person filling out form: Patient Other: \_\_\_\_\_ Relationship to patient \_\_\_\_\_

Reason for coming to the clinic (problems, symptoms, etc) \_\_\_\_\_

Current Medications \_\_\_\_\_

Circle any of the following you use more than once per week:

*Aspirin Acetaminophen (Tylenol) Ibuprofen (Advil, Nuprin) Antacids Sinus or Allergy Medications (OTC/RX)*

*Nebulizers or Inhalers Ointments Antidepressants Laxatives Nose Drops or Sprays*

*Other* \_\_\_\_\_

Allergies to medications \_\_\_\_\_

Patient's occupation: Works at \_\_\_\_\_ Retired from \_\_\_\_\_ Student in \_\_\_\_\_ grade

Have you been injured from a chemical-related incident (*spill, pesticide, spray*, etc.)? N/Y Explain \_\_\_\_\_

Have you had extensive dental work (root canals, mercury fillings, amalgams, etc.) N/Y Please describe \_\_\_\_\_

Have you been tested or treated for allergies before? N/Y When? \_\_\_\_\_

By whom? \_\_\_\_\_ Address \_\_\_\_\_

Phone \_\_\_\_\_ Fax Number \_\_\_\_\_

Circle type of Testing: Intra-dermal (injected into skin), Prick (skin is "poked"), Scratch, RAST (blood test),

Other \_\_\_\_\_

Type of Treatment: Allergy injections? Y/N How long? \_\_\_\_\_ Date of last dose \_\_\_\_\_

How Often: More than weekly, once per week, every two weeks, monthly, or seasonally if needed.

Currently receiving? N/Y Any symptom improvement? \_\_\_\_\_

Arm swelling? N/Y How much? \_\_\_\_\_

Or, have you had treatment by oral Allergy Drops? Y/N If yes, how often? \_\_\_\_\_

Have you ever taken Prednisone, Decadron, Medrol, or others \_\_\_\_\_ by mouth?

Or received cortisone-type injections such as "Depo-Medrol", Decadron, Kenalog, others \_\_\_\_\_

Have you even taken birth control pills? N/Y Which one? \_\_\_\_\_ for how long? \_\_\_\_\_

Have you had a strong reaction to allergy treatment or testing? N/Y Describe \_\_\_\_\_

Have you ever been tested for food allergies? N/Y Circle type: *Elimination or rotary diet, Sublingual (under-tongue) test,*

*Intradermal, Prick, Scratch, RAST, Cytotoxic test or ALCAT test. Other* \_\_\_\_\_

Who did this testing? \_\_\_\_\_ Address \_\_\_\_\_

Phone \_\_\_\_\_ Fax Number \_\_\_\_\_

If appropriate, circle type of treatment for food allergies: *A rotary diversified diet, Elimination diet, Injections, Sublingual Therapy, Other* \_\_\_\_\_

How much alcohol do you drink per day / or week ( \_\_\_\_\_ # beer \_\_\_\_\_ # wine \_\_\_\_\_ # liquor)

Describe your tobacco use (type, amount used per day) \_\_\_\_\_

Do you travel extensively? Y/N Do you travel by: car plane other \_\_\_\_\_

Family Medical History	Patient	Mother	Father	Grandparents	Siblings	Aunts/Uncles
Major Illnesses	_____	_____	_____	_____	_____	_____
Surgeries	_____	_____	_____	_____	_____	_____
Allergies	_____	_____	_____	_____	_____	_____
Additional Family History	_____					

### **Diet**

List foods that give you problems and describe the problems: \_\_\_\_\_

\_\_\_\_\_

List any food additives that cause you problems (*MSG, citric acid, food colorings, etc*) \_\_\_\_\_

List any foods that you avoid and why? \_\_\_\_\_

Are you currently on a special or modified diet? N/Y Circle: *Rotation, Low Salt, Pritkin, Weight Reduction, Low Cholesterol, Diabetic or Hypoglycemic, Atkins, Stone Age or Maker's Diet, Vegetarian, Vegan, Other, Describe* \_\_\_\_\_

Do you crave or binge on any foods? N/ Y Describe \_\_\_\_\_

How many meals do you eat each week at: \_\_\_\_\_ home; \_\_\_\_\_ fast food restaurants; \_\_\_\_\_ other restaurants; \_\_\_\_\_ school; \_\_\_\_\_ other \_\_\_\_\_ Where? \_\_\_\_\_

### **What foods do you eat on a typical day for:**

Breakfast: \_\_\_\_\_

Lunch: \_\_\_\_\_

Dinner: \_\_\_\_\_

What are your 3 favorite everyday foods? 1) \_\_\_\_\_ 2) \_\_\_\_\_ 3) \_\_\_\_\_

Do you consider yourself a sugar lover? N/Y Are you excessively sleepy after meals? N/Y/Sometimes

WOMEN: Do you have premenstrual food cravings? N/Y Describe \_\_\_\_\_

Circle any of the following places you experience itching: *Roof of mouth, between shoulder blades, inside the ear canal, the rectum, the nose, inside elbows (rash here? N/Y), behind knees (rash? N/Y)* \_\_\_\_\_  
other \_\_\_\_\_

Do you get hives? How often? \_\_\_\_\_ Canker sores? How often? \_\_\_\_\_

Do you experience the following? (circle all that apply) *Foul breath odor, belching, gas, stomach ache, nausea, vomiting, bloating, constipation, diarrhea, other* \_\_\_\_\_

If known, under what conditions do these symptoms occur? \_\_\_\_\_

Do you re-taste foods after you have eaten them? N/Y Which foods? \_\_\_\_\_

Do you notice any of the above symptoms 5 to 60 minutes after meals? N/Y Do you awaken from sleep between 1:00 a.m. and 5:00 a.m.? N/Y If so, do you crave or feel hungry for particular foods? N/Y

Please List \_\_\_\_\_

Do you ever consciously notice that one side of your nose is blocked more than the other? N/Y

Does this change later? NY \_\_\_\_\_

Which food would you miss most if it were removed from your diet? \_\_\_\_\_

**Circle the number of servings you eat each week from these categories:**

Wheat products (breads, pastas, pizza, cookies, cereals)	0	1	2	3	4	5	6	7	8+
Corn products (popcorn, lunch meat, chips, tacos, cereals)	0	1	2	3	4	5	6	7	8+
Other grains (rice, oats, oatmeal, etc)	0	1	2	3	4	5	6	7	8+
Dairy products (milk, cheeses, yogurt, ice cream, butter)	0	1	2	3	4	5	6	7	8+
Goat/Sheep, Other Dairy (specify)	0	1	2	3	4	5	6	7	8+
Yeast (baking, nutritional, mushrooms, vinegar, salad dressing, soy sauce, ketchup, mustard)	0	1	2	3	4	5	6	7	8+
Red meats (beef, hamburger, steak, pork, etc)	0	1	2	3	4	5	6	7	8+
Other proteins (chicken, turkey, fish, seafood, etc)	0	1	2	3	4	5	6	7	8+
Eggs (also products containing eggs, like mayonnaise)	0	1	2	3	4	5	6	7	8+
Fruits	0	1	2	3	4	5	6	7	8+
Vegetables	0	1	2	3	4	5	6	7	8+
Peanut products (including peanut butter)	0	1	2	3	4	5	6	7	8+
Soy foods/soy products (TSP, tofu, soy sauce)	0	1	2	3	4	5	6	7	8+
Snack foods (potato chips, other nuts, etc)	0	1	2	3	4	5	6	7	8+
Chocolate, candy, cookies, sugar, etc.	0	1	2	3	4	5	6	7	8+
Beverages (Caffeinated, Soda, Juices, Diet)	0	1	2	3	4	5	6	7	8+
Coffee (even decaf)	0	1	2	3	4	5	6	7	8+

**Candida**

Have you been on antibiotics frequently in the past? N/Y If yes, how long? \_\_\_\_\_

List any side effects (for example, diarrhea) \_\_\_\_\_

Have you experienced frequent: *vaginal infections, yeast infections, OR infections of the prostate gland?* N/Y

When on antibiotics, is there an increase in vaginal or prostate symptoms? N/Y

Describe \_\_\_\_\_

Have you experienced rectal itching when on antibiotics? N/Y Describe \_\_\_\_\_

Do you have frequent fungal infections of the nails-N/Y fingernails toe nails

How about other fungal infections? N/Y Location \_\_\_\_\_

Have you had problems with of the following? *Thrush, Ringworm, Jock itch, Athlete's foot*

Do you have issues with any other skin symptoms, such as *cracked or split nails, cracking fingertips and/or cuticles*? Describe \_\_\_\_\_

Do you have any problems with calluses? N/Y \_\_\_\_\_

Do you crave any of the following: Sugar/Candy \_\_\_\_\_ Breads \_\_\_\_\_ Pastries \_\_\_\_\_

Do you have symptoms when you drink alcoholic beverages? N/Y Symptoms \_\_\_\_\_

Are you bothered by premenstrual syndrome? N/Y

If yes, how does PMS affect you? \_\_\_\_\_

**Environmental Factors**

	Home	Work	School	Other
List average hours spent per day at	_____	_____	_____	_____
How long have you lived/been going to this building	_____	_____	_____	_____
What is the age of the building (years)	_____	_____	_____	_____
Location ( <i>city/residential/industrial/town/rural/farm</i> )	_____	_____	_____	_____
Type of building ( <i>single family/apartment/mobile/office</i> )	_____	_____	_____	_____
Type of heating ( <i>forced air/hot water/radiant</i> )	_____	_____	_____	_____
Type of heating fuel ( <i>natural gas/LP gas/oil/electric/wood</i> )	_____	_____	_____	_____
Carpeting type and age ( <i>shag/short pile/wall to wall/partial</i> )	_____	_____	_____	_____
Has there been water damage to this building?	_____	_____	_____	_____
Was the building remodeled in the last 2 years?	_____	_____	_____	_____
List dust or bug problems in this building	_____	_____	_____	_____
List pets at this building	_____	_____	_____	_____
Comments to explain any items further	_____			

**Indicate things in your environment that make you feel unwell (list specific products or items and describe your symptoms)**

Perfumes/aftershaves \_\_\_\_\_ Fabric store odors \_\_\_\_\_

Soaps/detergents \_\_\_\_\_ Newspaper print \_\_\_\_\_

Disinfectants \_\_\_\_\_ Downs/feathers \_\_\_\_\_

Insect control products \_\_\_\_\_ Grass/pollen/trees \_\_\_\_\_

Pets/animals \_\_\_\_\_ Moldy areas \_\_\_\_\_

Soft plastics/vinyl/latex \_\_\_\_\_ Vehicle exhaust \_\_\_\_\_  
 Cleaning fluids/sprays \_\_\_\_\_ Natural gas \_\_\_\_\_  
 Bed pillows \_\_\_\_\_ Tobacco smoke \_\_\_\_\_  
 Others \_\_\_\_\_

**Please rate each symptom according to degree of severity, 0 being “no problem” at all, 10 being most severe:**

_____ Headache	_____ Muscle pain
_____ Cough (color of expectrant)	_____ Joint pain
_____ Frequent colds	_____ Fatigue
_____ Sneezing	_____ Itchy between shoulder blades
_____ Wheezing	_____ Itchy roof of mouth
_____ Nasal Itching	_____ Itchy ears
_____ Nasal Drainage	_____ Itchy throat
_____ Watery Eyes	_____ Sore Throat
_____ Itchy Eyes	_____ Eczema
_____ Puffy Eyes	_____ Insomnia
_____ Rest/sleep after eating	_____ Diarrhea with mucus
_____ Belching	_____ Irritable Bowel Syndrome
_____ Bloating	_____ Halitosis

**ALLERGY SYMPTOMS:**

**Please check the listed patterns in which your symptoms have occurred during this past year and make any comments you have about them:**

\_\_\_ Worse indoors \_\_\_\_\_  
 \_\_\_ Worse outdoors \_\_\_\_\_  
 \_\_\_ Increase in symptoms within 30 minutes after going to bed \_\_\_\_\_  
 \_\_\_ Symptoms recur or increase with return of cold weather \_\_\_\_\_  
 \_\_\_ Nasal symptoms with little or no itching of eyes \_\_\_\_\_  
 \_\_\_ Worse in air conditioning \_\_\_\_\_  
 \_\_\_ Symptoms increase or occur while dusting or sweeping \_\_\_\_\_  
 \_\_\_ Symptoms are worse outdoors 4:30 to 8:30 p.m. \_\_\_\_\_  
 \_\_\_ Symptoms increase in cooling evening air \_\_\_\_\_  
 \_\_\_ Symptoms are worse in damp places \_\_\_\_\_  
 \_\_\_ Nasal symptoms without eye itching while mowing grass or playing on lawn \_\_\_\_\_  
 \_\_\_ Worse while raking leaves or playing in leaves \_\_\_\_\_  
 \_\_\_ Worse September to heavy frost \_\_\_\_\_

\_\_\_ Symptoms increase around October 1<sup>st</sup> \_\_\_\_\_  
 \_\_\_ Runny nose, sneezing, itchy eye or nose \_\_\_\_\_  
 \_\_\_ Itching of the whole eye \_\_\_\_\_  
 \_\_\_ Itching of the inside corners of the eye only \_\_\_\_\_  
 \_\_\_ Symptoms worse on clear days \_\_\_\_\_  
 \_\_\_ Worse outdoors 7-11:00 a.m. \_\_\_\_\_  
 \_\_\_ Improved indoors, especially in air conditioning \_\_\_\_\_  
 \_\_\_ Flare when going from air-conditioned room to open air \_\_\_\_\_  
 \_\_\_ Little or no symptoms when it is raining \_\_\_\_\_  
 \_\_\_ Worse in basements \_\_\_\_\_  
 \_\_\_ Symptoms are worse around feed mills \_\_\_\_\_  
 \_\_\_ Symptoms are worse in barns \_\_\_\_\_  
 \_\_\_ Symptoms are worse in certain homes \_\_\_\_\_  
 Whose home? \_\_\_\_\_  
 \_\_\_ React to cats or in home with cats \_\_\_\_\_  
 \_\_\_ React to dogs or in home with dogs \_\_\_\_\_  
 \_\_\_ React to other animals/birds \_\_\_\_\_  
 Which? \_\_\_\_\_

**Please circle the months in which you usually have any symptoms of any degree**

January	February	March	April
May	June	July	August
September	October	November	December

**If your symptoms are not the same year-round, which two months are:**

the **least** bothersome \_\_\_\_\_

the **most** bothersome \_\_\_\_\_

How old is your residence? \_\_\_\_\_

Do you have *attached/detached* garage? N/Y Breezeway? N/Y

Is it a house, an apartment, mobile home, or other \_\_\_\_\_

Basement? N/Y Circle basement conditions that apply: *dry, damp, musty, ever flooded*

Crawl-space? N/Y Circle crawl-space conditions that apply: *dry, damp, musty, ever flooded*

Do you live in: *wooded area, city, residential, high density area, industrial area, farm*

How long have you lived here? \_\_\_\_\_

Have there ever been animals in the home? N/Y Specify when & type \_\_\_\_\_

List current pets \_\_\_\_\_

How long have you had pets? \_\_\_\_\_ Have these pets been treated for fleas? N/Y

Did you experience symptoms with pets? N/Y Describe \_\_\_\_\_

Type of Home insulation: *fiberglass, sawdust, styro-foam, UFFI (urea-foam), cellulose (ground newspapers or blown-in) formaldehyde, other*\_\_\_\_\_

When was it installed?\_\_\_\_\_

Type of flooring: *slab concrete, plywood, hardwood, carpet, tile, vinyl tile (VCT)*

Carpet type, if known: *synthetic, wool, cotton, other*\_\_\_\_\_

Type of carpet padding: *rubber/plastic, natural fiber, other*\_\_\_\_\_

Type of heating system: (circle all appropriate) *gas, fuel oil, coal, electric, wood-burning fireplace, wood-burning stove, steam, space heater (electric, propane, kerosene, other*\_\_\_\_\_)

Heat delivery system: *forced air, gravity, radiators, electric panels*

Do you burn wood often? N/Y Describe (*open fireplace, wood furnace, etc*)\_\_\_\_\_

Type of Air Filters: *fiberglass, Electronic, HEPA, Other*\_\_\_\_\_

Humidifiers: *on furnace, room humidifier*

Air conditioning: *whole house, room units, none/fans*

Air purifiers used? N/Y Type\_\_\_\_\_ Brand\_\_\_\_\_

Room/s where used\_\_\_\_\_

Type of Drinking water: *Well water, city water, filtered water*\_\_\_\_\_

Any spays or chemical treatments used on *lawn, trees, shrubs, or inside house?*

Any Symptoms noted\_\_\_\_\_

Have you or any members of household stopped smoking? N/Y When\_\_\_\_\_

Are any members of household still smoking? N/Y\_\_\_\_\_

Indoors? N/Y \_\_\_\_\_

Any rooms with either new furniture or new carpet? Which rooms? \_\_\_\_\_

Are there rooms of house or garage where symptoms are worse? \_\_\_\_\_

List any family members' *hobbies which involve glues, chemicals, metals, inhalants, or solvents* you feel may be pertinent\_\_\_\_\_

Indicate whether the following household appliances are gas or electric:

*Gas Electric Stove*

*Gas Electric Water Heater*

*Gas Electric Clothes Dryer*

Has your home recently been painted?\_\_\_\_\_ Any recent remodeling? (describe)\_\_\_\_\_

Have you been away from your home or your environment in the last several years? N/Y

If yes, where?\_\_\_\_\_ When away, were there any changes in your symptoms? N/Y

If yes, how? \_\_\_\_\_When visiting the ocean, are you symptom-free? N/Y

## **Bedding**

Indicate what type of fabrics:

Mattress: *Regular or other* \_\_\_\_\_

Mattress cover: *Cotton, Allergy -proof Other* \_\_\_\_\_

Pillow: *Feather, foam rubber, Dacron, Buckwheat hulls other* \_\_\_\_\_

Covers: *Wool, cotton, synthetic, down (feathers) other* \_\_\_\_\_

Is the bedroom carpeted? N/Y Type if known \_\_\_\_\_

Allergies get worse at night, or upon lying down? \_\_\_\_\_

What type of laundry detergent used? \_\_\_\_\_

Fabric Softener N/Y Brand? \_\_\_\_\_

## **Work Environment**

At work, are your symptoms: *better, worse, the same*

Are you bothered by smoking in your work place? N/Y

Is there any particular place or room at work which bothers you? Specify \_\_\_\_\_

Have you been exposed to any of the following items at work (either at present or in the past)?

(Please circle all applicable) *Asbestos, Chemicals, Petrochemicals, Fumes, Mists (like spray paints),  
Paints, Biologicals (blood, serum, etc.), Dusts (grain, cotton, wood, etc.), Agricultural sprays or chemicals  
Other* \_\_\_\_\_

Do you think your work and/or machines have anything to do with your symptoms? N/Y

Describe these materials or machinery \_\_\_\_\_

Are there materials used at work that you think have something to do with your symptoms? N/Y

How long have you been employed in this environment? \_\_\_\_\_

## **Miscellaneous Information**

How good is your sense of smell? *Above Average, Average, Below Average, None/gone*

How long gone? \_\_\_\_\_

Do you feel worse overall health during certain times of the year? N/Y

What season: *Winter Spring Summer Fall*

Have you been unable to work because of partial or total disability? N/Y

Give dates and reasons \_\_\_\_\_

Do you feel that your allergy or illness is school or work related? No Not sure Yes \_\_\_\_\_

Explain \_\_\_\_\_

Are you exposed to fumes or chemicals at work or home? (*crop spraying, highway/factory pollution, etc.*)

No Not sure Yes -Name chemicals and describe ill effects \_\_\_\_\_

What are your favorite hobbies? \_\_\_\_\_

Do your hobbies involve working with *paint, glue, solvent or chemicals*: N/Y

Describe \_\_\_\_\_

How many days of work or school did you miss last year (if applicable)? \_\_\_\_\_ days.

Primary Reason: \_\_\_\_\_

Circle any odors you smell when you enter your home: *gas musty odor mold chemicals none*

Explain: \_\_\_\_\_

Do you wear perfume, cologne, or other scents? N/Y \_\_\_\_\_

What precautions do you take for perceived allergy problems? (*pillow covers, air cleaners, etc*)

## **Pediatric Client Information**

Age of patient \_\_\_\_\_

Were there problems during the child's: prenatal *period* delivery *postnatal period*

If yes, explain \_\_\_\_\_

Did the child have colic as a baby? N/Y \_\_\_\_\_

Was the child breast-fed exclusively? N/Y How many months? \_\_\_\_\_

Did the child's mother drink milk while nursing the child? N/Y Type: \_\_\_\_\_

Was the child fed formula? N/Y Explain any problems tolerating formula: \_\_\_\_\_

How old was the child when supplemental feeding was begun? \_\_\_\_\_ months

How old when solid foods were begun? \_\_\_\_\_ months

Is the child now on a full diet? N/Y Details \_\_\_\_\_

Were/are there foods that bother the child? N/Y

Explain \_\_\_\_\_

Has the child's physical development been normal? N/Y Current height \_\_\_\_\_ (percentile of normal \_\_\_\_\_ )

Current weight \_\_\_\_\_ (percentile of normal \_\_\_\_\_ )

Have you followed the recommended vaccination schedule? \_\_\_\_\_

How many infections has the child had in the last three months? \_\_\_\_\_ the last year? \_\_\_\_\_

Does the child have any chronic or recurring infections? N/Y Explain \_\_\_\_\_

List any unusual or serious infections the child has ever had (meningitis, pneumonia, etc) \_\_\_\_\_

Are there stuffed animals in the room? N/Y

Does the child sleep with these? N/Y

Is the child's school performance normal? N/Y Explain issues \_\_\_\_\_

**Please explain any abnormalities or delays in these following areas of development:**

Large motor skills (running, climbing, swimming)

Small motor skills (coloring, cutting, handwriting)

Hearing \_\_\_\_\_

Vision \_\_\_\_\_

Taste \_\_\_\_\_

Smell \_\_\_\_\_

Speech \_\_\_\_\_

Bladder/bowel control \_\_\_\_\_

Other \_\_\_\_\_

Please include any additional information that would be useful in understanding the patient's history:

