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ADULT AND PEDIATRIC ALLERGY, ASTHMA AND CLINICAL IMMUNOLOGY

Allergy History Questionnaire

Patient Name _____ **Date:** _____

What over the counter meds have you tried?
check as many as apply

		dates:
Claritin		
Alavert		
Benadryl		
Tavist		
Afrin		
Tylenol Allergy		
Other		

What Prescription products have you tried?
check as many as apply

		dates:
Allegra		
Allegra D		
Claritin/ Claritin D		
Clarinex		
Zyrtec/ Zyrtec D		
Nasal Spray		
Other		

What are you symtoms? check as many as apply

Itchy Eyes		Swollen Eyes	
Sneezing		Fatigue	
Runny Nose		Inability to sleep	
Itchy Skin		Asthma	
Hives		Chronic Sinusitis	
Scratchy Throat		Chronic Bronchitis	

		Sinus Pain	
		Congestion	

When did you first notice these symptoms? _____

How often do you have symptoms?

Daily	
Weekly	
Monthly	
Other	

Do you have a job or daily activities that require mental alertness?

Yes: ☐

Describe: _____

No: ☐

Have you seen a physician for this in the past: _____

Reviewed by: _____ Date: