

Allergy Skin Testing History Questionnaire

Please read carefully and complete all questions

Patient Name: \_\_\_\_\_ Age: \_\_\_\_\_

Referred By: \_\_\_\_\_ Date: \_\_\_\_\_

In order to evaluate the allergy skin test accurately, certain medications **must not** be taken before the test is performed. These medications include **antihistamines** and some **tranquilizers**. If you are taking a medication known as a **beta-blocker** or are taking **Strattera** (Atomoxetine), you cannot undergo allergy skin testing.

(Please refer to "Preparation for Allergy Skin Testing" for a complete list of medications to avoid.)

The day of your test, do not change your diet. Please eat breakfast before a morning test and lunch before an afternoon test.

The testing session will last 60-90 minutes. If you are running a fever, have an asthma attack, or if allergy symptoms become severe, please call our office to reschedule your testing.

Testing is performed on the inner forearms and one upper arm, so please wear a loose-fitting short-sleeved or sleeveless top. You may also bring a drink (soda, water, juice, etc.) with you to the test.

Chief Complaint: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Please list all medications you are currently taking: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Please answer each question as best you can:

Headaches:    yes    no                      If yes, which part of head? \_\_\_\_\_

What makes it worse? \_\_\_\_\_

Can you tell when a headache is starting? \_\_\_\_\_

Sneezing:    yes    no                      If yes, what might induce it or make it worse?

\_\_\_\_\_

Is it seasonal or related to a time or location?

Eyes:                                      Please circle all symptoms that apply to you:

itching    burning    puffy    watery    redness

If itching, where? (corner? all over?) \_\_\_\_\_

Nose:                      post-nasal drip (drainage down the throat)?                      yes    no

runny nose/nasal drainage?    yes    no

blockage? left, right or both (circle one)                              yes    no

congestion?    yes    no

if drainage, is it clear?    yes    no

if not clear, what color is it? \_\_\_\_\_

if drainage, is it thick or thin? (circle one)

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Ears:	Do your ears drain or run? if yes, is drainage clear or cloudy? _____ itching?	yes	no
Breathing:	Do you wheeze? if yes, what induces wheezing? _____ Did you wheeze as a child? Have you been diagnosed with asthma? if yes, when and by whom? _____	yes yes yes yes	no no no no
Skin:	hives? rashes? What causes an outbreak? _____ itching? if yes, where and when? _____ burning? if yes, where and when? _____  What kind of laundry detergent do you use? _____ Do you wear eye makeup? if yes, what kind? _____	yes yes  yes  yes yes	no no  no  no no
	Do you regard yourself as being nervous?	yes	no
	Do you feel that being upset aggravates your symptoms?	yes	no
	Have you experienced any problems with personality or behavioral changes?	yes	no
	Do you have insomnia or other sleeping problems? If yes, please describe: _____	yes	no
	Do you get laryngitis or a raspy voice?	yes	no
	Do you get frequent sore throats?	yes	no
	Do you get fungal infections? (e.g. athlete's foot, yeast infections, nail infections)	yes	no
	Do you smoke or use tobacco? if yes, please indicate which type you use: cigarettes cigars pipes chew snuff other _____ if no, does second-hand smoke bother you?	yes yes	no no
Animals:	Do you have a pet or pets? if yes, please indicate what kind: _____ kept outside or inside? _____ How long have you had this/these pet(s)? _____ Do your symptoms get worse around any particular animals? if yes, which kind? _____	yes   yes	no   no
	Are you exposed to an excessive amount of dust, fumes, or chemicals?	yes	no (if yes, circle all that apply)
	Do you have a loss of smell?	yes	no

Please indicate if you experience an increase, decrease, or no change in symptoms with the following conditions:

(circle one)

in cold weather	increase	decrease	no change
in warm weather	increase	decrease	no change
in air-conditioning	increase	decrease	no change

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on windy days	increase	decrease	no change
on rainy days	increase	decrease	no change
when inside	increase	decrease	no change
when dusting, sweeping	increase	decrease	no change
change of seasons	increase	decrease	no change
March to May	increase	decrease	no change
May to July	increase	decrease	no change
August to October	increase	decrease	no change
November to March	increase	decrease	no change
when going to bed	increase	decrease	no change
upon rising in the morning	increase	decrease	no change
in damp locations	increase	decrease	no change
after mowing grass	increase	decrease	no change
when playing in grass	increase	decrease	no change
when heat comes on	increase	decrease	no change

Have you had allergy testing before? yes    no  
 If yes, please indicate approximate year \_\_\_\_\_ and type (circle one): intradermal    scratch    RAST  
 other \_\_\_\_\_  
 name of doctor who performed/recommended test: \_\_\_\_\_  
 Were you treated for allergies previously? yes    no  
 If yes, for how long? \_\_\_\_\_

Do you have any known allergies? \_\_\_\_\_

**FAMILY HISTORY:** Please indicate below if any of your blood relatives have any of the following conditions by writing in their relationship to you:

bronchial asthma	_____	frequent colds	_____
emphysema	_____	hay fever	_____
sinus problems	_____	post-nasal drip	_____
thyroid problems	_____	food allergy	_____
stomach problems	_____	migraines	_____
hives/skin rashes	_____	eczema	_____
colitis	_____	acid reflux	_____

**WORK AND HOME ENVIRONMENT:**  
 If you are employed, please list place of employment: \_\_\_\_\_  
 Do your symptoms get worse at home or work? \_\_\_\_\_  
 Are you exposed to air-conditioning? \_\_\_\_\_  
 What type of heat does your home use? \_\_\_\_\_  
 Do you have blown insulation in your home? \_\_\_\_\_  
 Do you have problems with mold or mildew in your home or at work? yes    no  
 if yes, please describe: \_\_\_\_\_  
 What type of home do you live in? (e.g. ranch, 2-story, trailer, etc.) \_\_\_\_\_  
 Do you live in the suburbs (outside of town)? \_\_\_\_\_  
 What type of pillow do you use? \_\_\_\_\_

Please list your hobbies: \_\_\_\_\_  
 \_\_\_\_\_  
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Please list anything else not included in this questionnaire that you feel is pertinent to your allergy symptoms:

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Thank you and we look forward to seeing you,  
The Allergy Department