



QUESTIONNAIRE
ADVANCED ALLERGY RELIEF OF AZ, llc
(602) 866-3500

Patient Name: _____ **Date:** _____
Address: _____ **Date of Birth:** _____
City, State, Zip: _____ **Home#:** _____
Gender (circle one): **MALE** **FEMALE** **Work#:** _____
Referred by: _____ **Referring Physician:** _____

Although your history and symptoms are very important in our analysis of your condition, it is also important for us that you understand:

- *We do not treat symptoms or diseases.*
- *Allergy is not a disease, rather a condition.*
- *A symptom is an attempt by your body to tell you something.*
- *We will attempt to find the underlying cause.*
- *We do not use needles, drugs, supplements or avoidance in this program.*
- *There is no single "healthy" diet that will work for everyone.*
- *Just because food is considered "healthy", does not mean it is "healthy" for you.*
- *Your diet consists of everything you **eat, drink, breathe, or rub on your skin.***
- *Our procedures are safe and painless.*
- *Our bodies are like snow flakes...No two are alike!*

Briefly describe the reason for your visit and what you hope to accomplish: _____

AGE WHEN SYMPTOMS WERE FIRST OBSERVED

- | | |
|-------------------------|------------------------|
| Infant (Age 0-2) | Child (Age 3-5) |
| Child (Age 6-12) | Adolescent (Age 13-18) |
| Adult (Age 19-25) | Adult (Age 26-40) |
| Adult (Age 41 and over) | |

DID YOU SUFFER FROM ANY TYPE OF PHYSICAL, CHEMICAL OR EMOTIONAL TRAUMA JUST BEFORE YOUR SYMPTOMS WERE FIRST OBSERVED? _____

HAVE YOUR SYMPTOMS EVER GONE AWAY FOR ANY PERIOD OF TIME? _____

PREVIOUS DIAGNOSIS OF ALLERGY

Yes and allergy shots helped
Yes and medication helped
None

Yes but allergy shots did not help
Yes but medication did not help

FAMILY MEMBERS WITH ALLERGIC SYMPTOMS

Mother
Brother/Sister
Son/Daughter
None

Father
Grandparents
Spouse

FREQUENCY & SEVERITY OF ALLERGY SYMPTOMS

Constant/Chronic with little change
Present part of the time

Present most of the time
Present rarely

Prevents some normal activities
Slight interference with normal life

Considerable interference with normal life
No interference with normal life

SYMPTOMS ARE WORSE

- Outdoors and better indoors
- In the bedroom or when in bed
- During wet or damp weather
- During known pollen seasons
- When exposed to tobacco smoke
- When sweeping or dusting the house
- In air conditioning
- Tobacco smoke bothers me more than anything else
- At nighttime
- During windy weather
- When the weather changes
- In certain rooms or buildings
- With yard work, cut grass, leaves, hay or barns
- In areas with mold or mildew
- In fields or in the country

SYMPTOMS ARE BETTER

- After shower or bath
- Indoors
- After taking antihistamines
- In air conditioning
- During or after physical activity
- With allergy shots

What makes you feel better? _____

ANIMALS, INSECTS AND BIRDS THAT CAUSE SYMPTOMS ON EXPOSURE

- Dogs
- Horses or Cattle
- Bees
- None
- Cats
- Rabbits
- Other _____
- Rodents (mice, guinea pigs, etc.)
- Birds or Feathers

FOOD RELATED SYMPTOMS

- Symptoms flare 5-60 minutes after meals
- The smell or odor of some foods increases symptoms
- Some foods cause swelling of the mouth or tongue
- Some foods cause upset stomach or vomiting
- Symptoms occur with restaurant salad bars or Asian foods
- Symptoms occur with any regularly eaten food
- Preservatives, additives or food coloring increase symptoms
- Some foods are craved or addictive
- Some foods cause nasal symptoms
- Some foods cause rashes or hives
- Some foods cause diarrhea
- Some foods cause headaches
- Some foods cause asthma
- No problem with foods

FOODS THAT CAUSE SYMPTOMS FROM ONE HOUR TO THREE DAYS AFTER EXPOSURE

- | | | |
|--|---|------------------------------------|
| <input type="checkbox"/> Eggs | <input type="checkbox"/> Milk | <input type="checkbox"/> Beef |
| <input type="checkbox"/> Corn | <input type="checkbox"/> Wheat | <input type="checkbox"/> Soybean |
| <input type="checkbox"/> Peanut | <input type="checkbox"/> Pork | <input type="checkbox"/> Fish |
| <input type="checkbox"/> Shellfish | <input type="checkbox"/> Orange or other citrus | <input type="checkbox"/> Potato |
| <input type="checkbox"/> Tomato | <input type="checkbox"/> Yeast | <input type="checkbox"/> Chocolate |
| <input type="checkbox"/> Coffee or Tea | <input type="checkbox"/> Other _____ | |
| <input type="checkbox"/> None | | |

CHEMICALS THAT CAUSE SYMPTOMS

- | | |
|---|---|
| <input type="checkbox"/> Insecticides & pesticides | <input type="checkbox"/> Paints & household cleaners |
| <input type="checkbox"/> Perfumes & cosmetics | <input type="checkbox"/> Gasoline or automobiles exhaust |
| <input type="checkbox"/> Stove or furnace emissions | <input type="checkbox"/> The smell of new fabrics or fabric store |
| <input type="checkbox"/> Chemicals in the workplace | <input type="checkbox"/> Laundry detergent |
| <input type="checkbox"/> Newsprint | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> None | |

WHEN ARE YOUR SYMPTOMS WORSE

- | | | | |
|------------------------------------|-----------------------------------|--------------------------------------|-----------------------------------|
| <input type="checkbox"/> January | <input type="checkbox"/> February | <input type="checkbox"/> Year around | |
| <input type="checkbox"/> May | <input type="checkbox"/> June | <input type="checkbox"/> March | <input type="checkbox"/> April |
| <input type="checkbox"/> September | <input type="checkbox"/> October | <input type="checkbox"/> July | <input type="checkbox"/> August |
| | | <input type="checkbox"/> November | <input type="checkbox"/> December |

MEDICATIONS

Do you take any of the following medications on a regular basis?

- Antihistamines (Benadryl, Actifed, Chlortrimeton, Tylenol Sinus, Tylenol Sleep, Dimetapp, Drixoral, Trimalin, Atarax, Claritin, Allegra, Zyrtec, etc)
- Bronchodilators (Albuterol, Ventolin, Proventil, Serevent, or OTS's such as Primatine Mist, etc)
- Steroid Inhalers (Asmacort, Flovent, Pulmicort, Beclovent, Aerobid, Advair, etc)
- Nasal Steroids (Beconase, Flonase, Nasacort, Rhinocort, etc)
- Medications that affect the immune system (Prednisone, Imuran, Methotrexate, Cellcept, Cyclosporine, Tacrolimus, etc)
- Chemotherapy

Please list any medications that you are currently taking: _____

SMOKING

Do you presently smoke? Yes No If yes, average number of cigarettes per day _____

If yes, at what age did you start? _____

Does anyone smoke in your home? Yes No

PREVIOUS ALLERGY EVALUTION

Have you ever seen an allergist? Yes No

Have you had allergy skin testing? Yes No

Did you have any positive reaction? Yes No

If yes, please list positive allergens (include any medications) _____

Have you ever received allergy injections? Yes No

WORK ENVIRONMENT

What is your occupation? _____

Are you exposed to chemicals or strong odors at work? Yes No

If yes, briefly explain _____

Are you symptoms worse while at work? Yes No

If yes, briefly explain _____

ANY ADDITIONAL INFORMATION YOU WOULD LIKE US TO KNOW? _____

ANYTHING ELSE YOU WOULD LIKE TO ASK? _____
