Berkshire Ear, Nose, Throat & Audiological Associates, P.C.

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ALLERGY SYMPTOM QUESTIONNAIRE

(Yes/No/Don't Know)	**Y**	**N**	**?**
Nasal/Sinuses			
Clear nasal discharge	[]	[]	[]
Thick/colored nasal	[]	[]	[]
discharge	[]	[]	[]
Nasal itching	[]	[]	[]
Constant congestion	[]	[]	[]
Occasional congestion	[]	[]	[]
Sniffles	[]	[]	[]
Sneezing	[]	[]	[]
Mouth breathing	[]	[]	[]
Snoring	[]	[]	[]
Eyes			
Redness	[]	[]	[]
Itching	[]	[]	[]
Excessive tearing	[]	[]	[]
Ears			
Popping	[]	[]	[]
Itching	[]	[]	[]
Hearing loss	[]	[]	[]
Fluid sensation	[]	[]	[]
Pain/discomfort	[]	[]	[]
Occasional infections	[]	[]	[]
Throat			
Itching throat/mouth	[]	[]	[]
Constant throat clearing	[]	[]	[]
Sore throat/discomfort	[]	[]	[]
Skin			
Eczema	[]	[]	[]
Hives	[]	[]	[]
Do you have cough? If yes,:	[]	[]	[]
Deep/productive	[]	[]	[]
Dry cough	[]	[]	[]
Daytime	[]	[]	[]
Nighttime	[]	[]	[]
When they occur, are your			
symptoms:	[]	[]	[]
Mild	[]	[]	[]
Moderate	[]	[]	[]
Severe	[]	[]	[]

Describe the symptom(s) that bother you most:

____
____
____

Do the following cause your symptoms or make them worse?	**Y**	**N**	**?**
Location:			
Indoors	[]	[]	[]
Outdoors	[]	[]	[]
At home	[]	[]	[]
At work	[]	[]	[]
Sheds/Barns	[]	[]	[]
Time of Day:			
Morning	[]	[]	[]
Afternoon	[]	[]	[]
At night	[]	[]	[]
During what seasons do you usually have symptoms?			
Winter	[]	[]	[]
Spring	[]	[]	[]
Summer	[]	[]	[]
Fall	[]	[]	[]

Do you have any of the following conditions (please circle):

Asthma
High blood pressure
Migraine headaches
Frequent headaches
Diabetes
Heart disease
Sinus problems
Nasal obstruction
Nasal polyps
Reflux
Thyroid disease

When did your symptoms first begin?

____

	Y	**N**	**?**
Do you use medication regularly for your nasal symptoms?	[]	[]	[]

What medications and do they help?

____
____
____
____

Do you have any food allergies? (Please list)

____
____

Drug Allergies:

Aspirin
Penicillin
Other_______________

	Y	**N**	**?**
Do any of your Immediate relatives have allergies?	[]	[]	[]

Have you ever had allergy testing? If so:

Blood test?
Skin test?
When______________
Where_____________
Did the test indicate allergies? If so, to what?

____
____
____
____

Have you received allergy shots?
When and for how long?

____

Exposure to smoke

Do you Smoke? Yes_____ No_____
Years smoked:____________________
Years stopped smoking:_____________
Other smoke exposure:_____________

Hobbies/Sports (Please list):

____
____
____
____

Animals/Pets at home (Please list):

____
____
____
____

Describe your occupations:

____
____
____
____

Do you think your work/school environment has anything to do with your symptoms? Yes______ No_____

Do you think that any material used in your occupation has something to do with your condiation? Yes___No____

Describe material(s): _______________
____

Where do you live? (Please circle)

In the city

In a neighborhood

Rural location

Housing type:

House

Condo/Apartment

Other:______________________

Is your dwelling (Please circle):

3-25 years old

Greater than 25 years

Mostly carpet

Musty smell

Known mold

Bedding (Please circle):

Is your pillow:

Cotton

Foam/rubber

Feather

Is your mattress:

Cotton

Foam/rubber

Feather

Heating/cooling (Please circle):

Humidifier: At home? At work?

Air conditioner: At home? At work?

Oil heating

Gas heating

Coal/wood heating

Electric heating

Other heating:__________________

Is there anything else about your symptoms/condition that you think might be important or unusual?

____
____
____
____
____
____

PLEASE STOP ANY ANTIHISTAMINES ONE WEEK PRIOR TO TESTING