Allergy Test Questionnaire

NAME: _____ **DOB:** _____

SYMPTOMS:

Please check any allergy symptoms you may have:

_____	cough	_____	running nose	_____	postnasal drip	_____	sneezing
_____	poor sense of smell	_____	nasal congestion	_____	nasal polyps	_____	hives
_____	dizziness	_____	itchy nose	_____	ear infections	_____	eczema
_____	headaches	_____	Itchy/watery eyes	_____	sinus infection	_____	snoring
_____	sinus pressure	_____	sore throat	_____	blocked ears	_____	fatigue

How long have you had allergy symptoms? _____

What time of year do you suffer most? _____

When are allergies particularly worst for you? ____ indoor ____ outdoor ____ am ____ pm ____ not sure

What triggers your allergy symptoms? _____

Do you have pets? ____ no ____ cat ____ dog ____Other: _____

Are your pets allowed in your bedroom? ____Yes ____ No

Do allergies disturb your sleep? ____ Yes ____ No

Do allergies cause you to miss school or work? ____ Yes ____ No

Have you ever been hospitalized for you allergy symptoms? ____ Yes ____ No

Have you ever had a severe reaction to immunizations? ____ Yes ____ No

What allergy medication(s) do you take and how often? _____

_____

Do you have asthma? ____ Yes ____ No

What are your asthma symptoms? _____

What triggers your asthma symptoms? _____

What medication(s) do you take for asthma and how often?_____

_____

Have you had ear, nose, or throat surgery before? ____ Yes ____ No

If yes, what type of surgery and when? _____

PREVIOUS TESTING:

Have you had allergy testing in the past? ____ Yes ____ No

If yes, when/where/what were the results? _____

If yes, did you receive allergy injections? _____

If yes, did you ever have a reaction to an allergy injection? _____

FOOD ALLERGIES

Do you have food sensitivities? ____ Yes ____ No If yes, what food? _____

Have you ever had hives or anaphylaxis (difficulty breathing, throat swelling) after eating a certain food?

____ Yes ____ No If yes, what food? _____

Do foods cause you to have diarrhea, gas, heartburn, nausea, vomiting, and/or chronic abdominal pain?

____ Yes ____ No If yes, what food? _____

SOCIAL HISTORY

Where do you live and for how long? (If less than 1 year, where did you live previously) _____

Do you smoke? ____ Yes ____ No

If yes, for how long and how much? _____

What are your hobbies? _____

Flagstaff Surgical Associates

Phone: 928-773-2222 Opt. 5 for Allergy flagstaffsurgical.com Fax: 928-773-2287

SNOT- 20 Questionnaire

NAME: _____ **DOB:** _____

1. Consider how severe the problem is when you experience it and how frequent it happens, please rate each item below on how "bad" it is by circling the number that corresponds with how you feel. 2. Please mark the most important items affecting your health (maximum 5 items)	No Problem	Very Mild Problem	Mild or Slight Problem	Moderate Problem	Severe Problem	Problem as bad as it can be	5 Most Important Items
	0	1	2	3	4	5	
1. Need to blow nose	0	1	2	3	4	5	
2. Sneezing	0	1	2	3	4	5	
3. Running nose	0	1	2	3	4	5	
4. Cough	0	1	2	3	4	5	
5. Post-nasal discharge	0	1	2	3	4	5	
6. Thick nasal discharge	0	1	2	3	4	5	
7. Ear fullness	0	1	2	3	4	5	
8. Dizziness	0	1	2	3	4	5	
9. Ear pain	0	1	2	3	4	5	
10. Facial pain/pressure	0	1	2	3	4	5	
11. Difficulty falling asleep	0	1	2	3	4	5	
12. Wake up at night	0	1	2	3	4	5	
13. Lack of Sleep	0	1	2	3	4	5	
14. Wake up tired	0	1	2	3	4	5	
15. Fatigue	0	1	2	3	4	5	
16. Reduced productivity	0	1	2	3	4	5	
17. Reduced concentration	0	1	2	3	4	5	
18. Frustrated / restless / irritable	0	1	2	3	4	5	
19. Sad	0	1	2	3	4	5	
20. Embarrassed	0	1	2	3	4	5	
21. Nasal Obstruction	0	1	2	3	4	5	
22. Loss of smell or taste	0	1	2	3	4	5	

SCORE: _____

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