Michael J. Roberts, M.D., Inc.
F.A.A.A.A.I., F.A.C.A.A.I., F.A.A.P.
Diplomate American Board of Allergy and Immunology
(818) 887-1556
7230 Medical Ctr. Dr., #602 • West Hills, CA 91307

NAME _____ AGE ____ DATE _____

ALLERGY QUESTIONNAIRE

I. MAJOR REASON FOR VISIT (circle yes or no)

A. Nose Proolems	YES	NO
B. Chest Problems	YES	NO
C. Skin Proolems	YES	NO
D. Ear Problems	YES	NO
E. Eye Problems	YES	NO

F. Other _____

G. Of problems A through F, which seems most important to you? _____

II. DRUG ALLERGY / REACTION

A. Name of Drug _____ Reaction _____

III. SYMPTOMS

A. CHEST (circle yes or no)

1. Wheezing	YES	NO
If yes, what age did it begin _____		
2. Chronic Cough	YES	NO

3. How many days of school/work did you/your child miss in the past 6 months because of wheezing _____
4. Hospitalizations for Asthma _____

B. UPPER RESPIRATORY SYMPTOMS (circle yes or no)

1. Frequent nose congestion	YES	NO
2. Frequent discharge from nose	YES	NO
3. Frequent ear infections	YES	NO
4. Mouth breathing	YES	NO
5. Frequent sneezing	YES	NO
6. Noisy breathing / snoring during sleep	YES	NO

7. At what age did the nasal problems start _____

C. EYES (circle yes or no)

1. Redness / itching	YES	NO
2. Discharge	YES	NO

3. When did eye symptoms start _____

D. SKIN (circle yes or no)

1. Eczema (allergic skin rash)	YES	NO
a. Only as infant/child	YES	NO
b. Present now?	YES	NO
2. Hives, Welts	YES	NO
3. Dry skin	YES	NO

4. When did skin problems start _____

E. GASTROINTESTINAL (circle yes or no)

1. Frequent episodes of nausea, vomiting, abdominal cramps, bloating sensation, diarrhea	YES	NO
a. Association with specific foods	YES	NO
LIST _____		
2. Rash, Hives	YES	NO
a. Food Association	YES	NO
LIST _____		

F. STINGING INSECT ALLERGY (circle yes or no)

1. Reaction to bee, hornet, wasp or yellow jacket sting	YES	NO

a. Describe reaction _____ _____

IV. RELATIONSHIP OF SYMPTOMS TO POSSIBLE CAUSES

A. Seasonal difference between winter, spring, summer, fall — YES NO
Specify change in symptoms _____

B. Are symptoms worse during the day or the night or the same all the time _____

C. Symptoms increase with (circle yes or no)

1. Wind — YES NO
Symptom _____
2. Rain — YES NO
Symptom _____
3. Mowing lawn or playing in grass — YES NO
Symptom _____
4. Vacuuming, house dust — YES NO
Symptom _____
5. Colds or infections — YES NO
Symptom _____
6. Exposure to animals — YES NO
a. Which animal _____
Symptom _____
7. Weather change — YES NO
Symptom _____
8. Smog — YES NO
Symptom _____
9. Odors — YES NO
Symptom _____
10. Running — YES NO
Symptom _____
11. Tension, emotional upset — YES NO
Symptom _____
12. Laughter/Excitement — YES NO
Symptom _____

V. FAMILY HISTORY

Symptoms	Relationship to Patient	(circle)
A. Asthma	_____	YES NO
B. Bronchitis	_____	YES NO
C. Emphysema	_____	YES NO
D. Nose allergy/Hayfever	_____	YES NO
E. Hives	_____	YES NO
F. Skin allergy/Eczema	_____	YES NO
G. Cystic fibrosis	_____	YES NO

VI. ENVIRONMENT

A. Pets (circle yes or no)

1. Dogs YES NO
2. Cats YES NO
3. Rabbits YES NO
4. Horses YES NO
5. Birds YES NO
6. Other (list) _____

B. Does anyone smoke at home YES NO
If yes, list _____

VII. TREATMENT

A. Previous allergy skin tests or blood tests — YES NO
1. When _____ 2. By whom _____

B. Have you received allergy shots in the past — YES NO
1. For how long _____ 2. Were they effective YES NO

List all current medications; include over-the-counter preparations, vitamins, birth control pills etc. _____