Aloha Allergy and Immunology, LLC
Queens POB II
1329 Lusitana Street. Suite #603
Honolulu, Hi 96813

Allergy Questionnaire

Name:_____Age:_____Date:_____

Referring Doctor:
Reason for Consultation:
Years of residence lived here in Hawaii?_____
****

PLEASE ANSWER / CIRCLE ALL THAT APPLY

Asthma: Yes / No Age of onset: _____ Seasonal: **Yes / No**
Which Seasons: Spring / Summer / Fall / Winter
Which of the following worsens asthma: Infections (colds) / Dust / Exercise / Damp Weather / Laughing / Smoke / Cold Air / Strong Odors / Aspirin / ALL listed / NONE listed

List any **Foods (which foods), Animals (which animals), Drug medications (which drugs), OTHER (describe)** that also worsens asthma:

Time of day more frequent or worse: Early A.M / Late A.M. / Early P.M / Late P.M / No Pattern / OTHER (describe)

Nasal allergy: Yes / No Age of onset:_____ **Sinus Condition: Yes / No** Age of onset:_____
Which Season: Spring / Summer / Fall / Winter
Frequency of attacks: Daily / Weekly / Monthly / OTHER (describe)
Symptoms are: Runny / Stuffy / Sneezing / Headache / Post-nasal drainage / Itching / ALL listed / NONE listed
OTHER (describe):

Do you use nasal drop or nasal spray? Yes / No How Often? _____
Symptoms worsened by:

Skin Allergy: Yes / No Age of onset_____ Hives: Yes / No Rash: Yes / No
OTHER (describe):
Frequency of Episodes: Daily / Weekly / Monthly / OTHER (describe)

Suspected Causes: Animal dander / Food / Pollens / Grass / Trees / Dust mites / Chemical
OTHER: (describe)

Insect Sting Allergy: Yes / No Age of onset:____

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Which Insect do you suspect? Mosquito / Honey Bee/ Yellow Jacket / Wasp / Hornet
OTHER: (describe)
Describe Symptoms:

Food Sensitivities or Intolerance: Yes / No Age of onset____
Frequency of Episodes: Everyday / Weekly / Monthly / OTHER: (describe)

Describe Symptoms:

Is there anything else you wish to discuss with doctor?

Please List:
Daily Medication:

Frequent medication:

Occasional medication:

Known Drug Allergies:

Any Latex Allergy: Yes / No Previous Skin Test: Yes / No Previous Rast/IgE Blood Test: Yes / No

Previous Allergy Shots? Yes / No Do you smoke? Yes / No Does immediate family smoke? Yes / No

Basement? Yes / No Air conditioning? Yes / No Humidifier? Yes / No

Bedroom rugs/carpets? Yes / No Made of wool? Yes / No

Type of pillow: Feather / Cotton / Gel / Dacron /Other (describe):

Do you have any animal/s? Yes / No List Type of Animal/s?

Immediate family members (father, mother, children, etc) have asthma, nasal, sinus condition, or hay fever? Yes / No

Occupation: