Consult Requested By:_______________ Primary Care Physician:_______________

What are your goals for your visit with us today?_______________

____

Fill out the sections that address the symptoms you experience:

YES	NO	Symptoms	YES	NO	Symptoms
☐	☐	Breathing Difficulty (Asthma)	☐	☐	Insect Sting Reactions
☐	☐	Cough	☐	☐	Nasal Symptoms
☐	☐	Food Reactions/ Allergies	☐	☐	Other (please explain below)
☐	☐	Hives / Swelling			_______________

Past Allergy History:

YES	NO	History
☐	☐	Have you previously been seen for allergy care? Name of provider:_______________
☐	☐	Have you had allergy testing done before? Where:_______________
☐	☐	Have you received allergy shots before? When:_______________
☐	☐	Continuing on allergy shots started __________ years ago and receive them every __________ weeks

Previous Allergy or Asthma Medications (including OTC): Indicate if they helped improve condition

Helped	No Help	Medication
☐	☐	_______________
☐	☐	_______________
☐	☐	_______________

Hospitalizations & Surgeries due to Respiratory or Allergy Issues:

Age or Year	Reason for Hospitalization or Surgery

Social History:

CURRENT OCCUPATION:_______________ OCCUPATIONAL EXPOSURE:_______________

CHILD: Do they spend a lot of time outside of their primary residence (e.g. daycare, second home)? Yes / No

SMOKING HABITS:

___ Never smoked

___ Smoked previously, but quit _____ years ago

___ Currently smoke (Circle all that apply) Tobacco / Marijuana (THC) / eCigarettes (______ packs per day for ______ yrs)

Current Environment: Please select all that apply

YES	NO		YES	NO	
☐	☐	Air purifier	☐	☐	Other pets: _______________
☐	☐	Air conditioning (central / window)	☐	☐	Damp basement
☐	☐	Bedroom carpet	☐	☐	Forced air heat
☐	☐	Birds	☐	☐	Mold growth
☐	☐	Cats	☐	☐	Secondhand smoke
☐	☐	Dogs	☐	☐	Wood burning stove

ALLERGY QUESTIONNAIRE

PATIENT LABEL

59-01
Questionnaire

	FATHER	MOTHER	SIBLINGS	CHILDREN
ASTHMA				
ALLERGIES				
ECZEMA				
FOOD ALLERGY				
INFECTIONS				
THYROID DISORDER				

Other chronic family conditions such as cystic fibrosis, emphysema, recurrent hives or swelling, immune deficiency, cancer, diabetes, etc:

____

Review of Systems: Please select all that apply

YES	NO	Symptoms
General		
☐	☐	Fever / night sweats / chills
☐	☐	Growth or development problems
☐	☐	Unintentional weight loss or gain
☐	☐	Blood count problems (e.g. anemia)
☐	☐	Skin problems
☐	☐	Recurrent infections
☐	☐	Fatigue
Cardiovascular		
☐	☐	Heart problems
☐	☐	High blood pressure
☐	☐	Chest pain
☐	☐	Poor circulation
Eye/Ear		
☐	☐	Eye diseases (e.g. cataracts, glaucoma)
☐	☐	Hearing problems
Endo/Gyn		
☐	☐	Diabetes
☐	☐	Thyroid disorder
☐	☐	Pregnant or planning
☐	☐	Gynecologic problems

YES	NO	Symptoms
GI		
☐	☐	Upset stomach / ulcers
☐	☐	Reflux / heartburn
☐	☐	Irritable bowel
☐	☐	Liver disease
Oropharynx		
☐	☐	Sore throat
☐	☐	Sinus infections
☐	☐	Adenoids/tonsils removed
Ortho/Immuno/Rhuem		
☐	☐	Lupus or Rheumatoid arthritis
☐	☐	Bone or joint issues
Psychiatric		
☐	☐	Anxiety
☐	☐	Depression
Urinary		
☐	☐	Urinary or bladder problems
☐	☐	Prostate problems
Other		
☐	☐	Cancer
☐	☐	HIV infection

Physician Notes:

Name of person filling out form (print):______________________ Relation if not the Patient:______________

Physician's Signature:______________________ Date/Time:______________

Allina Health

ALLERGY QUESTIONNAIRE

PATIENT LABEL

59-01
Questionnaire