Drs. Girgis & Associates, S.C.

Hinsdale Elm Plaza ▪ 908 N. Elm, Suite 306 ▪ Hinsdale, IL 60521
La Grange Medical Office Building ▪ 5201 S. Willow Springs Road, Suite 240 ▪ La Grange, IL 60525
Oak Park Office and Sleep Center ▪ 1515 N. Harlem Ave, Suite 300 ▪ Oak Park, IL 60302
www.girgisent.com
Phone 630-323-5214 ▪ Fax 630-323-5297

Allergy History Questionnaire

Name____

Date____________________

Date of birth_______________ Height______________ Weight______________

Family Physician's name and address______________________________

Would you like your test results sent to your physician? ☐ Yes ☐ No

General:

Describe your allergy symptoms and when they began:

Please list any treatments or medications you have tried and how effective they were:

Please list any medications you are currently taking, including over the counter herbals, medications, aspirin, vitamins, etc:

Please list any medication allergies you have:

Please list any hobbies, travel or recreational activities:

Do you live in ☐ a house, ☐ an apartment, ☐ a townhouse, ☐ a condo?

In the following sections, please check the box if you have experienced any of the following:

The Ears:

☐ Ringing ☐ Drainage ☐ Dizziness ☐ Pain/pressure

☐ Frequent infections ☐ Temporary or permanent hearing loss

The Eyes:

Do you regularly experience:

☐ Watering ☐ Itching ☐ Glaucoma ☐ Red or swollen eyelids

☐ Puffiness around eyes ☐ Night blindness

When and how often?____

The Nose:

Do you regularly experience:

☐ Itchy nose ☐ Sneezing ☐ Runny nose ☐ Stuffiness ☐ Green or yellow nasal discharge

☐ Post nasal drip ☐ Poor sense of smell How often?______________________

Do you have nasal polyps? ☐ Yes ☐ No

The Throat:

Do you regularly experience:

☐ Swollen or sore tongue ☐ Hoarse voice ☐ Feeling that you have to clear your throat frequently

☐ Cold sores ☐ Bad breath ☐ Swollen lips or glands ☐ Itchy mouth or tongue

☐ Frequent infections or sore throat

How often?____

The Chest/Asthma:

☐ Wheezing ☐ Shortness of breath with exertion ☐ Chronic cough ☐ Shortness of breath at rest

☐ Frequent bronchitis ☐ Pneumonia

☐ Wheezing or shortness of breath that has awakened you from sleep

How often?____

Have you ever been diagnosed with asthma? ☐ Yes ☐ No

Has a physician prescribed an inhaler for you? ☐ Yes ☐ No

List any activities or times of the year which seem to trigger your breathing symptoms:

Gastrointestinal:

Do you regularly experience:

☐ Acid reflux, acid indigestion or heartburn ☐ Indigestion or bloating after meals ☐ Belching

☐ Constipation or diarrhea How often?____

List any foods that disagree with you: ____

Have you had colitis, ulcers or gallbladder problems? Describe:______________________________

Head and Neck:

Do you regularly experience headaches (sinus, migraine or other)? ☐ Yes ☐ No

List any medications you take for headaches:____

Do you feel lightheaded or "spacey" at times? ☐ Yes ☐ No

Are you drowsy after meals? ☐ Yes ☐ No

Are you tired all the time? ☐ Yes ☐ No

Skin, Joints and Muscles:

Do you regularly experience:

☐ Eczema ☐ Psoriasis ☐ Hives ☐ Rash ☐ Arthritis ☐ Cold feet

☐ Swollen joints ☐ Brittle nails ☐ Acne ☐ Fungal infection of skin or nails

Childhood History:

Did you experience any of the following as a child:

☐ Eczema ☐ Feeding problems ☐ Hyperactivity ☐ Frequent ear or throat infections

☐ Frequent or chronic cough ☐ Stomach aches ☐ Vomiting ☐ Diarrhea or constipation

Family History:

Have your parents, brothers or sisters had any of the following:

☐ Asthma ☐ Allergies/Hay fever ☐ Sinus problems ☐ Frequent headaches

☐ Other ____

List any hormone medications you are taking:

Women only:

Are you currently pregnant? ☐ Yes ☐ No

Do you get frequent yeast infections? ☐ Yes ☐ No

Dust and Mold:

Does any of the following seem to make your symptoms worse?

☐ Being in your home ☐ Being at work ☐ Being away from home ☐ Dusting

☐ Mowing the lawn ☐ Raking leaves ☐ Being in a basement ☐ Damp weather

☐ Having beer, wine or cheese

Feathers and Animals:

Does contact with any of the following seem to worsen your symptoms?

☐ Cat ☐ Dog

☐ Feather pillows or down comforters ☐ Other ____

List any pets you have or regularly visit: ____

Chemicals, Pollutants, Miscellaneous:

Does any of the following make your allergy symptoms worse?

☐ Vehicle exhaust ☐ City air pollution ☐ Paint fumes ☐ Smoke

☐ Reading the newspaper ☐ Exposure to powder, perfumes or cosmetics

☐ Other ____

Do you have ☐ a gas stove ☐ a gas furnace ☐ an oil or wood-burning furnace

☐ other ____

Describe what bothers you most and when:

Signature of provider performing testing:______________________________ Date:__________