Northern Allergy Clinic

New Patient Allergy Questionnaire

Name _____ DOB _____ Occupation _____

Email _____ (Yes to receive clinic notes via this email?) ____

How did you hear about the Northern Allergy Clinic? _____

Who is your regular GP? _____ of _____
(Can a copy of your notes from today be forwarded to them?) Yes ____ No ____

What body system are you here **today** about? Please **tick all** that apply

___1. **Nose/ Sinus/Eyes**. (Symptoms please tick)

blocked	nasal discharge
sneezing	loss of smell
itchy	frequent nose bleeds
sniffing	other _____

___ 2. **Mouth/ Throat**. (Symptoms please tick)

mouth breathing	post nasal drip/throat clearing
itchy palate	frequent sore throat
itchy throat	other _____

___ 3. **Chest/ Breathing**. (Symptoms please tick)

wheezing	chest tightness
chronic cough	sputum
shortness of breath	other _____

___ 4. **Stomach/ Digestion**. (Symptoms please tick)

bloating/distension	regurgitation
gas	abdominal pain
nausea/vomiting	diarrhoea
swallowing issues/ food gets stuck	other _____

___ 5. **Skin/ scalp**. (Symptoms please tick)

itch	sensitivity
rash	weeping
dryness	other _____

How long have you had your symptoms/how old were you when you first noticed them? _____

Have you ever been skin tested or had a blood test for allergies? _____ What year? _____

Please list all your current/ past significant medical conditions including medication allergies:

_____

Please list all your current medications and any natural health supplements you take regularly: _____

_____ **P.T.O**

<u>ONLY IF</u> you ticked body systems 1-3 (I.E NOSE /MOUTH /CHEST) please answer the following also:

Are your symptoms (tick one)

Perennial: Present all year round but worse at certain times
Seasonal: Only at certain times of the year e.g spring
Coming and going without any relation to the time of the year.

Are your symptoms worse (circle):

Indoors
Outdoors
At work
At home
At school
First thing in the morning/ on waking
Evenings
Around certain animals _____
In old housing like a batch
In air conditioning

Are your symptoms better overseas?

Do you have any pets at home or in the workplace: please list? _____

Do you notice a difference in your symptoms around certain animals? Please list _____

Have you been diagnosed with asthma? _____

	No	Occasionally	Frequently
Do your symptoms restrict your leisure/sport activities?			
Do you miss school/work because of your symptoms?			
Do your symptoms disturb your sleep?			
Do you have trouble concentrating because of the symptoms?			

What medications have you used to treat your symptoms?:

Type	Oral Antihistamine	Nasal spray	Antihistamine eye drops	Inhaler: preventer/ reliever
Name				
Colour (inhaler only)				
Frequency				
How long used for?				
Helpful?				

Do you have a family history of Asthma? _____ Who is affected? _____

Do you have a family history of Hay Fever? _____ Who is affected? _____