

New Patient Allergy Questionnaire

Email (Yes to receive clinic notes via this email?) How did you hear about the Northern Allergy Clinic?	Name	DOB	Occupation
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) post nasal drip/throat clearing mouth breathing post nasal drip/throat clearing itchy palate frequent sore throat itchy throat other 3. Chest/ Breathing. (Symptoms please tick) mother wheezing chest tightness chronic cough sputum shortness of breath other -4. Stomach/ Digestion. (Symptoms please tick) regurgitation gas abdominal pain nausea/vomiting diarrhoea swallowing issues/ food gets stuck other -5. Skin/ scalp. (Symptoms please tick) sensitivity itch sensitivity rash weeping dryness other	Email		(Yes to receive clinic notes via this email?)
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	How long have you had your sympton	ns/how old were y	ou when you first noticed them?
Please list all your current/ past significant medical conditions including medication allergies:	Have you ever been skin tested or had	d a blood test for a	allergies? What year?
	Please list all your current/ past signifi	icant medical conc	ditions including medication allergies:

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

ONLY IF 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?:

Туре	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?	
5 5 5		

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