

## 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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mouth breathing  post nasal drip/throat clearing    itchy palate  frequent sore throat    itchy throat  other	-		•
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shortness of breath  other			÷
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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? \_\_\_\_\_