

**ALLERGY ASSOCIATES & LAB., LTD.**

1006 E GUADALUPE RD  
 TEMPE, AZ 85283  
 PHONE: (480) 838-4296  
 FAX: (480) 820-1275

SURESH C. ANAND, M.D.  
 MIRIAM K. ANAND, M.D.  
 HOUSAM ALASALY, M.D.  
 TERA CRISALIDA, PA-C

2248 N ALMA SCHOOL RD, STE 104  
 CHANDLER, AZ 85224

6553 E BAYWOOD AVE, STE 103  
 MESA, AZ 85206

IF UNABLE TO KEEP APPOINTMENT, KINDLY GIVE 24 HOURS NOTICE

<b>ALLERGY QUESTIONNAIRE</b>	Patient's Name:	Account No.
OCCUPATION:	DATE:	

**Please try to answer these questions accurately as the information is of considerable importance to your allergist in the evaluation of your condition.** If you have difficulty with any of the questions, check with the nurse who will see you after you have completed this form.

What is your main reason for coming to see an allergist?

---



---



---

When did this problem start? \_\_\_\_\_

How severe is the problem?       mild                       moderate                       severe                       other: \_\_\_\_\_

Is the problem present most of the time? Yes No (circle one) If it is only present occasionally, how often does it occur?

Is it worse during certain months? Yes No (circle one) If yes, please list which months:

What relieves the problem? \_\_\_\_\_

What makes it more severe? \_\_\_\_\_

What other related symptoms are you having? \_\_\_\_\_

Where were you living when the problems started? \_\_\_\_\_

If you have moved since the symptoms began, list the cities or areas in which you have lived and indicate to the right of each area whether symptoms were unchanged, less severe, or more severe in that area.

AREAS	SEVERITY OF SYMPTOMS

What other symptoms do you have that you believe are due to allergies?

Have you been studied or treated by an allergist in the past or has any other physician done allergy skin tests or given injections for allergy. Yes No (circle one) Specify years and details:

---



---

Read the following list carefully and indicate by checking in the appropriate boxes to the left of each item, which items cause or aggravate, relieve or have no apparent effect upon your allergy symptoms. Even a small change is significant. Leave all boxes blank if you have never encountered the situation or item.

Cause or Aggravate	Relieve	No Change	ITEMS
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lawn mowing, grass contact
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Weed contact, specify: _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Blossoming trees, specify: _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High winds, riding in auto with open windows
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Raking leaves
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Musty, moldy or mildewed places or articles
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Going indoors
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Going outdoors
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sweeping, dusting, vacuuming in the house, dusty books, etc.
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Any animals, specify: _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Taking any medications (including aspirin, etc.) specify: _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Emotional upset
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Exertion or heavy exercise, specify: _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory infection, virus infection, flu
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Insect spray
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hair spray, cosmetics, talcums, aftershaves, perfumes, etc. specify: _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Air conditioning, swamp coolers, etc. specify: _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Antihistamines or nasal decongestants (Allegra, Claritin, Zyrtec, etc.) specify: _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Medications for wheezing (Albuterol, Maxair, Serevent, etc.) specify: _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Adrenalin or Epinephrine
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Steroids (Cortisone type drugs, i.e. nasal sprays and/or inhalers) specify: _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other drugs, specify: _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Very cold weather or changes in weather
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Trips to the mountains
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Trips to the desert
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Trips to the seashore
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Any other trips out the this area, specify place and time of year _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Menstrual periods and/or pregnancy, specify: _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tobacco smoke
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Anything else you have noticed, specify: _____

Have you ever had any of the following conditions? If so check the appropriate boxes & specify during which years (and if applicable, seasons) and in what area you were living at the time, if you have not already answered these above.

Hay fever

Nasal allergy all year ("sinus")

Asthma (wheezing, shortness of breath) describe: \_\_\_\_\_

---

Hives, urticaria, angioedema (facial swelling, etc.) Circle appropriate word or words.

Eczema

Skin rash due to allergy or contact, specify cause: \_\_\_\_\_

Poison oak, ivy or sumac rash, specify which ones: \_\_\_\_\_

Food Allergy, specify foods and what symptoms they cause. Specify and describe any other unusual reaction when you eat any particular food: \_\_\_\_\_

---



---

Drug allergy (specify the drugs and the symptoms which occur:  None that I know of

---



---



---

Unusual reaction to insect bites or stings. (Specify the insects, describe the reactions and give the dates when they occurred):

---



---

**PAST MEDICAL HISTORY:** Have you had in the past or do you currently have any of the following? (Please check the appropriate box.)

- |   |  |                                       |
|---|--|---------------------------------------|
| <input type="checkbox"/> Diabetes   | <input type="checkbox"/> ulcer of the stomach or duodenum  | <input type="checkbox"/> pneumonia    |
| <input type="checkbox"/> cataracts  | <input type="checkbox"/> COPD, chronic bronchitis, or emphysema  | <input type="checkbox"/> bronchitis   |
| <input type="checkbox"/> osteoporosis/osteopenia                                | <input type="checkbox"/> high blood pressure   | <input type="checkbox"/> heart attack |
| <input type="checkbox"/> glaucoma   | <input type="checkbox"/> GERD or acid reflux or hiatal hernia  | <input type="checkbox"/> Valley Fever |
| <input type="checkbox"/> Thyroid disease (high or low)                          | <input type="checkbox"/> Stroke  | <input type="checkbox"/> tuberculosis |
| <input type="checkbox"/> bleeding from the gastrointestinal tract               |  | <input type="checkbox"/> sleep apnea  |
| <input type="checkbox"/> autoimmune disease (e.g., lupus, rheumatoid arthritis) |  |                                       |
| <input type="checkbox"/> Cancer Type: _____                                     | How treated: <input type="checkbox"/> chemotherapy <input type="checkbox"/> radiation <input type="checkbox"/> surgery |                                       |
| <input type="checkbox"/> Other _____  |  |                                       |

**PAST SURGICAL HISTORY:** Please list all surgical procedures that you have had and list the **approximate** dates. (Include tonsillectomy.)

<u>Type of surgery</u>	<u>Approximate date of surgery</u>
_____	_____
_____	_____
_____	_____
_____	_____

**PRIOR DIAGNOSTIC TESTS:** Have you ever had any of the following exams?

<u>Test</u>	<u>Response</u>	<u>Approx. date of last test</u>	<u>Finding</u>
Colonoscopy	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	<input type="checkbox"/> normal <input type="checkbox"/> abnormal
Mammogram	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	<input type="checkbox"/> normal <input type="checkbox"/> abnormal
Chest x-ray	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	<input type="checkbox"/> normal <input type="checkbox"/> abnormal
CT scan of sinuses	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	<input type="checkbox"/> normal <input type="checkbox"/> abnormal
Cardiac stress test	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	<input type="checkbox"/> normal <input type="checkbox"/> abnormal
Bone mineral density test	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	<input type="checkbox"/> normal <input type="checkbox"/> abnormal
Prostate biopsy or blood test	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	<input type="checkbox"/> normal <input type="checkbox"/> abnormal
Skin biopsy	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	<input type="checkbox"/> normal <input type="checkbox"/> abnormal

If any of the above were abnormal, please explain:

---



---

Do you / did you ever smoke? Yes No If so, how much and what? \_\_\_\_\_  
 For how many years? \_\_\_\_\_ When did you quit? \_\_\_\_\_

**FAMILY HISTORY:** In your family as listed, did anyone have any of the following numbered conditions? Indicate the number to the right of the appropriate blood relative: (e.g., patient's mother 1, 6, 11)

Patient's mother	1. Hay fever	16. Leukemia
Patient's father	2. Nasal allergy	17. Lymphoma
Patient's brothers or sisters	3. "Sinus"	18. Other cancer
Patient's maternal aunts or uncles	4. Asthma	19. Immunodeficiency
Patient's maternal grandparents	5. Hives	
Patient's paternal aunts or uncles	6. Eczema	
Patient's paternal grandparents	7. Food allergy	
Patient's children	8. Drug allergy	
	9. Insect allergy	
	10. Emphysema or other lung diseases	
	11. Diabetes	
	12. Tuberculosis	
	13. Lupus	
	14. <i>Rheumatoid</i> arthritis	
	15. Thyroid disease	

**REVIEW OF SYSTEMS:** Please check if you have any of the following:

GENERAL:  None  unexplained weight gain or loss  unexplained fevers or shaking chills  
 waking up with your bedsheets or nightclothes soaking wet with sweat

SKIN/BREASTS:  None  Breast lumps  Nipple discharge  Hives  Eczema  
 Other rashes: \_\_\_\_\_

EYES/EARS/NOSE/MOUTH/THROAT:  None  Headaches  Lightheadedness  Visual changes  
 Nosebleeds  dentures or partials  hoarseness  tightness in the throat or choking sensation

CARDIOVASCULAR:  None  palpitations/racing or fluttering of heart  heart murmur  irregular heart rhythm  
 swelling of the feet/ankles  shortness of breath when lying flat

RESPIRATORY:  None  shortness of breath  wheezing  
 Cough If yes, do you bring up mucous?  No  Yes If yes, what does it look like?  clear  whitish  
 dark yellow/green/brown Other: \_\_\_\_\_ Do you cough up blood?  Yes  No

GASTROINTESTINAL:  None  Nausea  Vomiting  abdominal cramping  diarrhea  blood in stool  
 heartburn (burning in the stomach, chest, or throat)  taste of vomit in the mouth without vomiting  
 food sticking when swallowing  impaired liver function

GENITOURINARY:  None  blood in urine  trouble urinating  history of kidney stones  
 waking up more than 3 times at night to urinate  impaired kidney function

MUSCULOSKELETAL:  None  red, hot swollen joints  pain in joints  arthritis

NEUROLOGIC/PSYCHIATRIC:  None  seizures  anxiety  depression  thoughts of suicide

LYMPHATIC: Have you noticed any enlarged or swollen lymph nodes that won't go away?  No  Yes  
If yes, where?  neck  over the collar bones  armpits  borders between thigh and pelvis

**ADDITIONAL HISTORY THAT YOU WANTED US TO KNOW:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_