ALLERGY QUESTIONNAIRE

Your doctor has advised you to be tested for allergies, either to inhalants or foods, or both. Please take this questionnaire home and complete fully. Feel free to write down any extra pertinent information.

Please return with this completed questionnaire for your allergy evaluation with the doctors and nurses. They will go over the responses that you have given with you and determine what allergens you should be tested for. They will explain the risks and benefits of allergy testing and answer any questions that you may have..

Allergy testing is done through a two part series. Firstly a prick test which is done by "pricking"the skin and depositing a small drop of allergen under the skin on the forearm. Secondly, on the upper arm, it is done through a series of small wheals made on the skin, similar to a TB skin test. You **MUST** be off all antihistamine medication for at least 7 days prior to skin or RAST testing. Ask the allergy nurse what medications you may take. Occasionally the doctor will request a RAST test, which is bloodwork, be done instead of the skin testing. Skin testing is usually done in one visit but it may be two separate visits, depending on the type of allergens being tested. Each visit lasts approximately 30 minutes.

If your insurance company requires a referral for office visits and procedures, please make sure you have it when you come for the initial evaluation with Dr. Rubinstein. The codes your primary care doctor will need to know to process the referral are:

95015 Allergy testing code
477.9 Allergy diagnosis code

We ask that you get at least 6 visits to cover the evaluation, testing and follow-up appointments with Dr. Rubinstein. If you do not have your referral with you at the time of testing, the testing cannot be done.

Please also review our attached forms concerning testing and medications and if you have any any questions or concerns, please feel free to contact our allergy department.

***** Please be aware there is a $25 Fee in the event you do not show up for your appointment *****

HOME AND ENVIRONMENT:

What is your occupation?_____
What are your hobbies?_____
Are your symptoms worse at home?_____
Are your symptoms worse at work?_____
Are you exposed to excessive amounts of
dust, chemicals or fumes?_____
Are you around plants, dried or fresh flowers?_____

HEATING/COOLING SYSYTEM:

Electric?_____ Gas?_____
Oil?_____ Kerosene?_____
Fireplace?_____ Woodburning stove?_____
Air conditioning?_____ Air purifier?_____

LAUNDRY:

Type of detergent?_____
Fabric softner?_____
Bleach?_____

GENERAL ALLERGY QUESTIONS

YES NO — Do you have a frequent cough?
Daytime_____Nightime_____

YES NO — Frequent colds?

YES NO — Nasal drainage?
Clear_____ Discolored_____ Thick_____
Watery_____

YES NO — Nasal blockage?
Right side_____ Left side_____ Both sides_____

YES NO — Eye symptoms?
Itchy_____ Burning____ Watery____ Red_____

YES NO Headaches?
What part of your head?_____
What starts the headache?_____
What makes it worse?_____
What makes it better?_____

YES NO Fatigue?
Before eating?_____After eating_____
Chronic?_____

YES NO Shortness of breath?

YES NO Wheezing?
When in the cold?_____With Infections_____

YES NO Asthma?
As a child?_____

YES NO Eczema?
As a child?_____
Where?_____

YES NO Hives?
When?_____
Where?_____
Any known cause?_____

YES NO Dizziness?
When?_____

YES NO Loss of taste?
When?_____

YES NO Loss of smell?
When?_____

YES NO Fungus Infections?_____
Atheletes foot?_____Vaginitis?_____

YES NO Are you excessively nervous?

YES NO Do you perspire excessively?

YES NO Do you smoke?
How long?_____How much?_____

YES NO Does anyone around you smoke?

YES NO Do you have pets?

Dogs?_____ Cats?_____
Birds?_____ Other?_____

YES NO Are you allergic to Penicillin?

DESCRIBE WHAT SYMPTOMS BOTHER YOU THE MOST:

_____
_____
_____

CIRCLE WHETHER THESE SYMPTOMS GET BETTER, WORSE, OR STAY THE SAME UNDER THE FOLLOWING CONDITIONS:

INCREASE DECREASE SAME	COLD WEATHER
INCREASE DECREASE SAME	WARM WEATHER
INCREASE DECREASE SAME	AIR CONDITIONING
INCREASE DECREASE SAME	WINDY DAYS
INCREASE DECREASE SAME	MARCH TO MAY
INCREASE DECREASE SAME	MAY TO JULY
INCREASE DECREASE SAME	AUGUST TO OCTOBER
INCREASE DECREASE SAME	NOVEMBER TO MARCH
INCREASE DECREASE SAME	DAMP WEATHER
INCREASE DECREASE SAME	YARDWORK
INCREASE DECREASE SAME	HOUSEWORK, DUSTING
INCREASE DECREASE SAME	GOING TO BED
INCREASE DECREASE SAME	UPON RISING
INCREASE DECREASE SAME	DURING THE NIGHT

FOOD ALLERGY QUESTIONNAIRE

PLEASE READ EACH QUESTION CAREFULLY AND CIRCLE YES OR NO TO INDICATE YOUR ANSWER.

YES NO	Are there any foods you crave or eat frequently?_____
YES NO	Are there any foods that you dislike?_____
YES NO	Are you awakened from sleep with any of the following symptoms? Headache? Dizziness? Bloating? Dry cough?
YES NO	Do you or any member of your family have hay-fever, asthma, hives, chronic skin conditions, migraines, dizziness, bloating or dry cough?
YES NO	During your childhood, did you have asthma, eczema or food feeding problems.
YES NO	Do you frequently notice swelling of your feet, ankles, hands or face when arising in the morning.
YES NO	Do you have marked fatigue 2-3 hours after eating.
YES NO	Do you eat frequent snacks between meals?
YES NO	Do you have excessive chilling with a sudden change of temperature?
YES NO	Do you have frequent migraines?
YES NO	Do you have periodic numbness of the face, arms or legs for no apparent reason?
YES NO	Do you frequently experience bloating, abdominal distention or cramps following a meal?
YES NO	Do you have drowsiness, headaches or bloating after drinking a cocktail, beer or wine?