walla walla clinic

55 W. Tietan
Walla Walla, WA 99362
509-525-3720 ext 7604

Name: First Middle Initial Last

_____

Date of Birth _____ Age _____

Today's Date _____

Home Phone_____ Cell Phone_____

ALLERGY CLINIC
PATIENT IMMUNE QUESTIONNAIRE

Who sent you here? _____

Who is your regular family doctor? _____

What is your main problem? _____

History of Present Illness: _____

Please check any symptoms that you have. Mark with "?" if unsure.

Rhinitis Symptoms:

Eyes:
- ☐ Itchy
- ☐ Redness
- ☐ Watery
- ☐ Discharge

Nose:
- ☐ Itchy
- ☐ Sneezing
- ☐ Runny
- ☐ Stuffy
- ☐ Decreased Smell/Taste

Mouth/Throat:
- ☐ Throat Clearing
- ☐ Hoarseness
- ☐ Sore Throat

Asthma: Yes No

If yes, History of:
- ☐ Cough
- ☐ Shortness of Breath
- ☐ Chest Tightness
- ☐ Wheezing
- ☐ Intubation
- ☐ Hospitalization
- ☐ Prednisone Use

Skin:
- ☐ Hives/Rash
- ☐ Itchy Skin
- ☐ Eczema
- ☐ Swelling/Angioedema

Triggers: What makes your symptoms occur? Check all that apply.
- ☐ Cats
- ☐ Dogs
- ☐ Other Animals
- ☐ Feathers
- ☐ House Dust
- ☐ Molds
- ☐ Dampness
- ☐ Flowers
- ☐ Grass
- ☐ Trees
- ☐ Exercise
- ☐ Smoke
- ☐ Strong Odors

Seasonality: What time of the year do you have symptoms? _____

Previous Allergic Workup, Skin Tests and/or Shots: _____

_____

Environmental History:

Dwelling:
- ☐ House
- ☐ Apartment

Mattress:
- ☐ Waterbed
- ☐ Foam/Innerspring

Pillow:
- ☐ Down/Feathers
- ☐ Foam

Pets:
- ☐ Cat (indoor/outdoor)
- ☐ Dog (indoor/outdoor)
- ☐ Other (list)

Carpeting: Yes No

Food Allergy? Yes No If yes, what foods? _____

Insect Allergy? Yes No If yes, what Insects? _____

Medication Allergies? Yes No If yes, list medications: _____

_____

Please Answer Both Pages of the Questionnaire

Any History of Recurrent Infections? Yes No (if yes, please describe)_____

_____

Any History of GERD? Yes No

SOCIAL HISTORY:

Primary Language: English or _____

Race: American Indian, Alaska Native, Asian, Black/African American, Native Hawaiian/Pacific Islander, White, Hispanic/Latino

Occupation: _____

Any Unusual Exposures at Work? Yes No If yes, what? _____

Do you smoke? Yes No Current _____ packs per day x _____ years
Previous _____ packs per day x _____ years

Alcohol Use? Yes No

Recreational Drug Use: Yes No

Family History of Allergies? Yes No If yes, please list: _____

_____

Please Circle Any Ongoing Problems That You Currently Have:

General Health: Fever or Chills / Fatigue / Weight Loss / Weakness
Mental Health: Memory Problems / Depression / Stress / Anxiety
Neurological: Fainting / Poor Balance
Endocrine: Swollen Glands / Hot or Cold Intolerance
Ears/Nose/Throat: Hearing Problems / Eyesight Problems / Dental Problems
Respiratory: Cough / Shortness of Breath / Chest Tightness / Wheezing
Heart: Chest Pain or Pressure / Irregular Heartbeat / Leg Pain With Walking
Digestive: Swallowing Trouble / Indigestion / Abdominal Pain / Constipation / Diarrhea / Blood In Stools
Urinary: Leaking Bladder / Difficulty Urinating
Reproductive: Vaginal or Urethral Discharge / Hot Flashes
Skin: Rash / Itching / Skin Problems
Musculoskeletal: Joint Pain / Weakness
Hematological: Anemia / Low Platelets

Past Medical History/Past Surgical History: _____

_____

_____

Current Medications:

Prescription: Over-the-counter:

Previous Medications:

Prescription: Over-the-counter:

NAME and LOCATION of your Preferred Pharmacy: _____