

# walla walla clinic

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

## ALLERGY CLINIC PATIENT IMMUNE QUESTIONNAIRE

Name: First Middle Initial Last

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_

Today's Date \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

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

### Triggers:

- Cats
- Dogs
- Other Animals
- Feathers
- House Dust

What makes your symptoms occur? Check all that apply.

- Molds
- Dampness
- Flowers
- Grass
- Trees
- Exercise
- Smoke
- Strong Odors

### Skin:

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

**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:** \_\_\_\_\_