KALLAL MEDICAL GROUP

Allergy History Questionnaire

Patient Name: _____ DOB: _____

Contact Number: _____ Date: _____

1. During which months do symptoms most often occur?

☐ All Months

☐ January ☐ April ☐ July ☐ October

☐ February ☐ May ☐ August ☐ November

☐ March ☐ June ☐ September ☐ December

2. At what times and places are your symptoms **WORSE**?

☐ Morning ☐ Afternoon ☐ Evening ☐ Night

☐ At Home ☐ At Work/School ☐ Other Location: _____

3. Are your symptoms?

☐ Constant ☐ Erratic ☐ Rare

4. Do symptoms interfere with your activities?

☐ Not at all ☐ A little ☐ Moderately ☐ All the time

5. Family History:

☐ Asthma ☐ Eczema ☐ Sinus Problems ☐ Migraines

☐ Hay Fever ☐ Ulcers ☐ Nervous Disorder ☐ Colitis

Other: _____

Please Rate Your Symptoms 1 – 5 (#1 is low degree, 5 is high degree of symptom)

Eyes (itchy, watery or swelling):	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Ears (itchy, draining or congested):	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Nose (runny or congested):	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Headaches (allergy related):	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Cough (allergy related):	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Sneezing:	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

6. Are you currently being treated for allergies? ☐ Yes ☐ No

_____ _____

Patient Signature Date