FIRST PHYSICIANS GROUP
of Sarasota Memorial Health Care System

Allergy Health History Questionnaire

Name _____ **Date of Birth** _____

Allergy History	
Check if you have had any of the following	
☐ Hay Fever/Sinus	☐ Insect Allergy
☐ Asthma/Bronchitis	☐ Food Allergy
☐ Hives	☐ Drug Allergy
☐ Eczema	☐ Headache
Describe your major allergy symptoms:	

Current Health Concerns			
Check if you have had any of the following			
☐ Eyes		☐ Throat	
☐	Itching	☐	Itching
☐	Swelling	☐	Swelling
☐	Burning	☐	Post Nasal Drip
☐	Tearing	☐	Throat Clearing
☐	Discharge		
☐ Ears		☐ Chest	
☐	Itching	☐	Sputum
☐	Fullness	☐	Shortness of Breath
☐	Popping	☐	Chest Tightness
☐	Pain	☐	Nighttime Wheezing
☐ Nose		☐ Skin	
☐	Sneezing	☐	Dry Skin
☐	Itching	☐	Itching
☐	Runny Nose	☐	Hives
☐	Mouth Breathing	☐	Swelling
☐	Snoring	☐	Rash

Previous Treatment	
Check if you have taken any of the following	
☐ Allergy Shots	☐ Corticosteroids (ex. prednisone, dexacort)
Symptoms improved? ☐ Yes ☐ No	Symptoms improved? ☐ Yes ☐ No
Length of therapy?	How often do you use this medication?
☐ Antihistamines (ex. benadryl, zyrtec, claritin, allegra)	☐ Antibiotics
Symptoms improved? ☐ Yes ☐ No	Symptoms improved? ☐ Yes ☐ No
☐ Bronchodilators (ex. albuterol, theophylline, ventolin)	How often do you use this medication?
Symptoms improved? ☐ Yes ☐ No	☐ Other Therapy:
How often do you use this medication?	

Environmental Concerns
Check if you have had any of the following
Have you been hospitalized for breathing problems? □ Yes □ No
Have you been to the ER for breathing problems? □ Yes □ No
Have you ever been on a daily inhaler for asthma? □ Yes □ No
Have you ever had nasal polyps? □ Yes □ No
Have you had a previous sinus surgery? □ Yes □ No
What type of air conditioning do you have? □ None □ Central Air □ Window Unit
Do you keep your windows open often? □ Yes □ No
What type of flooring do you have in the home? □ Carpeting □ Wood/Laminate □ Tile □ Other
Do you have pets in the home? □ Yes □ No If yes, type?
Do you have any exposure to mold or mildew? □ Yes □ No
Do your symptoms become better when you are outside at the beach or on vacation? □ Yes □ No
Does a change in the weather influence your allergy symptoms? □ Yes □ No
Do strong odors, perfumes or fumes influence your allergy symptoms? □ Yes □ No
Does strenuous activity influence your allergy symptoms? □ Yes □ No

Family History						
Check if any family members have had any of the following						
	Mother	Father	Brother	Sister	Son	Daughter
Asthma						
Emphysema						
Hay Fever/ Sinus Allergy						
Eczema						
Seasonal Allergies						
Insect Allergies						
Food Allergies						
Medication Allergies						

Patient/Guardian Signature: _____ Date: _____

Rev. 5/6/2024

Scanning Category: Administrative/Patient Forms