East Memphis Allergy & Asthma, PLLC
3085 Fountainside Drive, Suite 202
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901-755-0550 fax 901-755-0464

ALLERGY QUESTIONNAIRE

Name:

Birth Date: Telephone:

Referring Physician

Please answer all questions as they relate to the person being seen.

Briefly describe the reason for your visit and what you hope to accomplish:

Have you ever had any of the following conditions?		
	Yes	No
Asthma	☐	☐
Drug Reactions	☐	☐
Eczema	☐	☐
Food Reactions	☐	☐
Frequent Heartburn	☐	☐
Frequent Infections	☐	☐
Hay Fever	☐	☐
Heart Problems	☐	☐
High blood pressure	☐	☐
Hives or swelling	☐	☐
Insect Reactions	☐	☐
Kidney Problems	☐	☐
Liver Problems	☐	☐
Nasal polyps	☐	☐
Pneumonia	☐	☐
Sinus surgery	☐	☐
Sinusitis	☐	☐
Tonsils/Adenoids Removed	☐	☐
Tuberculosis	☐	☐
Other (describe)		

Do you have any of the following symptoms?		
	Yes	No
Chronic Cough	☐	☐
Itchy Eyes	☐	☐
Itchy Nose	☐	☐
Runny or stuffy nose	☐	☐
Skin problems	☐	☐
Sneezing	☐	☐
Wheezing	☐	☐

Do any of the following factors make your symptoms worse?		
	Yes	No
Cold Air	☐	☐
Exercise	☐	☐
Housework	☐	☐
Mold or Mildew	☐	☐
Smoke	☐	☐
Strong Odors	☐	☐
Yardwork	☐	☐
Other (describe)		

List any reactions you have had to foods:				
Food	Symptoms	Can foods be eaten now?	Yes	No
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐

Have you ever had skin testing before? ◯ Yes ◯ No

If yes, where?

Have you ever had allergy shots before? ◯ Yes ◯ No

Please list all current medications and doses if possible

Have you ever been hospitalized and/or had surgery?	If yes, please list reason and approximate dates