



**VALLEY INTENSIVISTS, PULMONOLOGISTS AND
SLEEP SPECIALISTS**

1200 E. Savannah Ave. Suite 12
McAllen, TX 78503
Tel: (956) 688-6300 Fax: (956) 688-6303

ALLERGY QUESTIONNAIRE

PATIENT INFORMATION

Name: _____ Date of Birth: _____

Date Completed: _____

ALLERGY HISTORY

Do you believe you have allergies?

Yes No

SYMPTOMS (CHECK ALL THAT APPLY)

Symptom	Frequency	Severity
<input type="checkbox"/> Runny / Stuffy / Itchy Nose	<input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Seasonal <input type="checkbox"/> Rare	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe
<input type="checkbox"/> Sneezing	<input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Seasonal <input type="checkbox"/> Rare	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe
<input type="checkbox"/> Watery / Itchy Eyes	<input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Seasonal <input type="checkbox"/> Rare	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe
<input type="checkbox"/> Cough / Throat Clearing	<input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Seasonal <input type="checkbox"/> Rare	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe
<input type="checkbox"/> Wheezing / Shortness of Breath	<input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Seasonal <input type="checkbox"/> Rare	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe
<input type="checkbox"/> Skin Issues (Hives, Rashes, Eczema)	<input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Seasonal <input type="checkbox"/> Rare	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe
<input type="checkbox"/> Sinus Problems / Congestion	<input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Seasonal <input type="checkbox"/> Rare	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe
<input type="checkbox"/> Ear / Throat Itching	<input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Seasonal <input type="checkbox"/> Rare	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe

ASTHMA HISTORY

Have you been diagnosed with asthma? Yes No

If yes:

Age at diagnosis: _____

Severity: Mild Moderate Severe



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TRIGGERS (CHECK ALL THAT APPLY)

- Pollen Mold Insect Stings → Specify: _____ Smoke / Irritants
 Dust Pets Foods → Specify: _____ Other: _____
 Mold Weather Changes Medications → Specify: _____

REACTIONS

Please describe any significant allergic reactions:

MEDICATION HISTORY

Do you take medications for allergies? Yes No

If yes, list: _____

Do you take over-the-counter allergy medications? Yes No

PRIOR TESTING / TREATMENT

Have you had allergy testing? Yes No

If yes: Date: _____ Provider: _____

Have you received allergy injections (immunotherapy)? Yes No

If yes: When: _____

OFFICE USE ONLY:

- Completed by patient
 Completed with staff assistance