Central Georgia Pulmonary Associates
840 Pine Street, Suite 780
Macon, GA 31201
478-744-2445

Allergy Questionnaire - Part A

Patient Name_____ Birthdate _____

Reviewed by _____ Date_____

Yes	No	
☐	☐	1. Do you experience any of these symptoms more than twice per year: Cough, cold, congestion, difficulty breathing, headaches, wheezing, runny nose, sore throat, itchy/ irritated eyes, sinus pain, ear pain, unexplained fatigue, skin irritation, snoring?
☐	☐	2. Have you ever been diagnosed with asthma or bronchitis?
☐	☐	3. Do you experience symptoms of allergies?

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Allergy Questionnaire - Part B

To be filled out with allergy counselor after initial screening

1. What symptoms are you experiencing? (From #1 on Part A) _____

_____

2. How often do you experience these symptoms? _____

3. Do you have any of these symptoms?

☐ Cough	☐ Runny Nose	☐ Nasal Polyps	☐ Eczema
☐ Wheezing	☐ Nasal Congestion	☐ Poor Sense of Smell	☐ Hives / Swelling
☐ Shortness of breath	☐ Itchy Nose	☐ Ear Infections	☐ Headaches
☐ Chest tightness	☐ Itchy / Watery Eyes	☐ Sinus Infections	☐ Snoring
☐ Sneezing	☐ Postnasal Drip	☐ Blocked Ears	☐ Fatigue
☐ Phlegm / sputum (Color _____)		☐ Other _____	

4. Which of the following seems to bother you or trigger/cause the above symptoms?

☐ Grass	☐ Cats	☐ Cosmetics	☐ Drafts
☐ Nervousness	☐ Hay	☐ Dogs	☐ Aerosol sprays
☐ House Dust	☐ Cold Air	☐ Mold & Mildew	☐ Horses
☐ Perfumes	☐ Smoke	☐ Humidity	☐ Basements
☐ Other Animals	☐ Insecticides	☐ Pollution	☐ Weather changes
☐ Leaves	☐ Alcoholic Beverages	☐ Odors	☐ Exercise
☐ Latex (rubber)	☐ Insect bites/strings; Describe reaction: _____		
☐ Foods. List foods and reactions: _____			
☐ Other. List sources and reaction: _____			

5. When are your symptoms worst? ☐Year round

☐ January	☐ February	☐ March	☐ April
☐ May	☐ June	☐ July	☐ August
☐ September	☐ October	☐ November	☐ December

6. Are symptoms better away from home? ☐Yes ☐No If yes, when? _____

7. Have you ever had an allergy skin test or blood test? ☐Yes ☐No If yes, results: _____

8. Have you ever had allergy injections? ☐Yes ☐No If yes, when? _____

9. Have you received cortisone (prednisone, methylprednisolone, etc.) drugs? ☐Yes ☐No
If yes, when? _____ How much? _____

10. Are you on allergy medications? ☐ Yes ☐No What meds? _____

11. What is your occupation? (current or former) _____

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Is patient.....

☐On beta blocker? ☐ Pregnant? ☐ Heavily tattooed?

☐ Significantly immunocompromised or have malignancy or severe chronic illness?

If yes to above, select blood test

Wheezing or having difficulty breathing?

Experiencing active hives or extensive dermatitis?

If yes to above, treat symptoms and schedule for another day

Having symptoms consistent with food allergies?

If yes to above, consider skin panel and food panel

Indications

Inhalant Panels:	☐ Skin Test	☐ Blood Test
Food Panels:	☐ Skin Test	☐ Blood Test

Schedule skin test for (Date) _____

Patient Name _____ Date _____ Reviewed by _____