

EMORY HEALTHCARE

EMORY VOICE CENTER

Department of Otolaryngology-Head and Neck Surgery

ALLERGY QUESTIONNAIRE

Name: _____ DOB: _____ Date: _____

Please fill in the blanks and circle applicable answers. Feel free to add additional comments. Base your answers on your own observations, NOT on what you have been told by friends or other physicians.

1. Do you have any of these symptoms? (please circle)

Sneezing	Yes	No	Shortness of breath	Yes	No
Running nose	Yes	No	Wheezing	Yes	No
Nasal congestion	Yes	No	Cough	Yes	No
Ear congestion	Yes	No	Sinusitis	Yes	No
Itchy eyes	Yes	No	Hives	Yes	No
Puffy eyes	Yes	No	Eczema	Yes	No
Headaches	Yes	No	Dizziness	Yes	No
Bronchitis	Yes	No	Otitis	Yes	No

2. Are you worse in any season? Yes No
If yes, which season? spring summer fall winter

3. Have you ever had --
a **severe** reaction to anything? Yes No

If yes, to what? _____

an **anaphylactic** reaction to anything? Yes No

If yes, to what? _____

a previous allergy workup? Yes No

by whom? _____ when? _____

4. What is your occupation? _____

5. Do you work around:

dust and dirt? Yes No

chemicals? Yes No

animals? Yes No

6. Do you have any problems at work? Yes No

If yes, please describe: _____
