

Allergy Clinic Questionnaire

Date:	Name:	Date of Birth:
Occupation:	Ethnicity:	Phone:
Email:	Gender:	NHI (if known):
Address:		
NOK/Emergency Contact: Phone: Relationship to you:		
Current GP & Medical Centre:	Pronouns: <i>(eg. His/him, she/her, they/them)</i>	

List your main symptoms or complaints (with duration):

A:

B:

C:

D:

Write down any medications (including non-prescription medications, alternative medications, creams, inhalers and sprays) please include both trade/generic names of the medications, strength and how often you take them:

Name the Drug:	Strength:	Frequency Taken:

Answer the following with yes or no (please tick) and any additional comments can be made below:

Have you had allergy tests before? Yes No

If Yes please indicate which: Skin Testing Blood testing Patch testing

Briefly describe the result of these tests:

Have you had immunotherapy (desensitisation) before? Yes No

If Yes, to which allergen?

Have you ever had a severe reaction to a bee or wasp sting? Yes No

Have you had an anaphylactic reaction before?
(Sudden severe collapse/shock after food, drugs, or any cause) Yes No

What was the cause?

Do you suffer from asthma? Yes No Do you suffer from eczema? Yes No

Do you suffer from hives? (Urticaria) Yes No Do you suffer from hay fever? Yes No

Do you suffer from sinus troubles? Yes No Do you suffer from frequent colds? Yes No

Do you suffer from persistent cough? Yes No Do you suffer from diarrhoea? Yes No

Do you suffer from abdominal cramps? Yes No

Is your condition seasonal? Yes No

If Yes, which season is worse?

How often do you have attacks?

How long do they last?

Have you had an operation on your sinuses? Yes No

Comments:

Contact Allergy

Have you ever had a skin reaction to jewellery? Yes No

Have you ever had a skin reaction to skincare products or cosmetics? Yes No

Have you ever had a patch test? Yes No

Childhood Allergic History

As a child did you have asthma? Yes No As a child did you have eczema? Yes No

As a child did you have runny nose (Rhinitis)/hay fever? Yes No

As a child did you have vomiting, diarrhoea, colic? Yes No

Family History

Has any of your first degree relatives (parents or siblings) had:

Asthma? Yes No Relationship: _____

Eczema? Yes No Relationship: _____

Rhinitis (hay fever)? Yes No Relationship: _____

Please write down any family history particularly of allergy, autoimmune problems or immunology (for example recurrent infections). If possible please specify which particular relatives suffered from these problems and if they were from your mother's or father's side:

Food History

Do you suspect any foods causing symptoms? Yes No

If Yes, which foods and what symptoms are associated with these foods?

Are you omitting any food(s) at present? Yes No

Which foods?

Environmental History

Do you have a cat? Yes No Do you have a dog? Yes No

Are your symptoms better on holidays? Yes No

Are your symptoms worse at work? Yes No

Do you have any hobbies? Yes No

If Yes, what are your hobbies?

Are your symptoms brought on or worsened by exercise? Yes No

Comments:

Drug History

Are you sensitive/allergic to any drugs? Yes No

If Yes, please list the drug(s) and what reaction you had:

Drug:	Reaction:

General Medical History

Do you have high blood pressure? Yes No

Are you diabetic? Yes No Are you pregnant? Yes No

Do you smoke? Yes No

If Yes, for how many years have you smoked and how many cigarettes per day?

Would you like your consult letters to be sent to your GP? Yes No

If Yes, name of your GP: _____

Is there any other information you would like to share that would be useful?

PLEASE EMAIL THIS COMPLETED FORM TO US BEFORE YOUR APPOINTMENT

IF THERE ARE ANY ADDITIONAL DOCUMENTS YOU WOULD LIKE TO SEND TO US THAT MAY ASSIST WITH THE CONSULTATION PLEASE DO SO.