Sidney Devins, M.D.

ALLERGY QUESTIONNAIRE

Patient's Name: _____
Date of Birth: _____

Please try to answer these questions accurately as the information is of considerable importance to your allergist in the evaluation of your condition. If you have difficulty with any of the questions, check with the nurse who will see you after you have completed this form.

What is your main reason for coming to see an allergist?

_____

_____

_____

When did this problem start?

_____

How severe is the problem? ___mild ___ moderate ___ severe ___ other:_____
Is the problem present most of the time? Yes No (circle one) If it is only present occasionally, how often does it occur?

_____

Is it worse during certain months? Yes No (circle one) If yes, please list which months:

_____

What relieves the problem?

_____

What makes it more severe?

_____

What other related symptoms are you having?

_____

_____

Where were you living when the problems started?

_____

What other symptoms do you have that you believe are due to allergies?

_____

Have you been treated by an allergist in the past or has any other physician done allergy skin tests or given injections for allergy. Yes No (circle one) Specify years and details:

_____

Have you ever had any of the following conditions? If so check the appropriate boxes & specify during which seasons and in what area you were living at the time, if you have not already answered these above.

___ Hay fever
___ Nasal allergy all year ("sinus")
___ Asthma (wheezing, shortness of breath) describe: _____
___ Hives, urticaria, angioedema (facial swelling, etc.) Circle appropriate word or words.
___ Eczema
___ Skin rash due to allergy or contact, specify cause: _____
___ Poison oak, ivy or sumac rash, specify which ones: _____
___ Food Allergy, specify foods and what symptoms they cause. Specify and describe any other unusual reaction when you eat any particular food:_____

_____

Unusual reaction to insect bites or stings. (Specify the insects, describe the reactions and give the dates when they occurred):

_____

_____

Do you have any of the following pets(circle the following): cat/ bird/ dog / other: _____

Read the following list carefully and indicate by checking in the appropriate boxes to the left of each item, which items cause or aggravate, relieve or have no apparent effect upon your allergy symptoms. Even a small change is significant. Leave all boxes blank if you have never encountered the situation or item.

Cause or Aggravate	Relieve	No Change	Items
			Lawn mowing, grass contact
			Weed contact, specify:
			Blossoming trees, specify:
			High winds, riding in auto with open windows
			Raking leaves
			Musty, moldy, or mildewed places or articles
			Going indoors
			Going outdoors
			Sweeping, dusting, vacuuming in the house, dusty books, etc
			Any animals, specify:
			Emotional upset
			Exertion or heavy exercise, specify:
			Respiratory infection, virus infection, flu
			Hair spray, cosmetics, talcums, aftershaves, perfumes, etc. (We do not test for these) specify:
			Air conditioning, swamp coolers, etc. specify:
			Antihistamines or nasal decongestants (Allegra, Claritin, Zyrtec, etc.) specify:
			Medications for wheezing (Albuterol, Serevent, etc.) specify:
			Adrenalin or Epinephrine
			Steroids (Cortisone type drugs, i.e. nasal sprays and/or inhalers, etc.) specify:
			Other drugs, specify:
			Trips out of this area, specify place and time of year
			Menstrual periods and/or pregnancy, specify:
			Tobacco smoke
			Anything else you have noticed, specify:

IMMUNOTHERAPY PATIENT CONSENT FORM

Immunotherapy, hypo-sensitization, or allergy injections should be administered at a medical facility with a medical physician present since occasional reactions may require immediate therapy. These reactions may consist of any or all the following symptoms; itchy eyes, nose or throat; nasal congestion; runny nose; tightness in the throat or chest; coughing; increased wheezing; lightheadedness; faintness; nausea and vomiting; hives; generalized itching and shock; the last under extreme conditions.

Reactions, even though unusual, can be serious and rarely fatal. You are required to wait in the medical facility in which you receive the injections for 20 minutes after each injection. If the patient is 17 years of age or younger, a parent or legal guardian must be present during the waiting period. I verify that I (or patient) am not taking beta blocker medications or that if I am, I have discussed the risks/benefits of doing so with my physician.

I have read (if a new patient) or re-read (if established patient) the patient information sheet on immunotherapy and understand it. The opportunity has been provided for me to ask questions regarding the potential side effects of immunotherapy and these questions have been answered to my satisfaction. I understand that every precaution consistent with the best medical practice will be carried out to protect me against such reactions. I also agree that if I have an allergic reaction to the injections that the physician-in-charge has permission to treat said reaction.

I acknowledge the fact with my signature that I am authorizing the office to bill for allergen vaccines, even if, for any reason, I decide not to initiate the allergen immunotherapy program after the vaccine has been made. Vaccines may be prepared up to 1 ½ weeks prior to my appointment. I agree to obtain prior authorization, if needed from my insurance plan.

Patient_____ Date Signed_____

Parent or Legal Guardian_____ Date Signed_____

As a parent or legal guardian, I understand that I must accompany my child throughout the entire 20 minute wait.

Witness_____ Date Signed_____