# ALLERGY IMPACT QUESTIONNAIRE

**PATIENTS NAME:** ______________________ **D. O. B.** _____/_____/______ **DATE OF SERVICE:** _____/_____/______

**OFFICE STAFF ONLY: ICD-9 CODES FOR PATIENT:** _________ : _________ : _________ : _________ : _________

**1.** Do you think you suffer from Allergies? _____ Yes / _____ No

**2.** Are the symptoms all year around or seasonal? Year Long / Seasonal

**3.** How long do your symptoms last during an allergy flare up? Less than 7 days / More than 7 days

**4.** What time of the day are your symptoms the worst? Morning / Afternoon / Night / All day

**5.** Are the symptoms worse in the spring, fall or both? Spring / Fall / Both

**6.** Do you have any sinus drainage issues? _____ Yes / _____ No If Yes, When? AM / PM / All day

**7.** Do you ever have watery or itchy eyes? Always / Most Times / Sometimes / Never

**8.** Do you cough or sneeze on a regular basis? _____ Yes / No _____ If Yes, When? ________________

**9.** Do you have regular Upper Respiratory Infections? _____ Yes / _____ No If Yes, $< 3$ or $> 3$ per year

**10.** Do you think you might be allergic to Animals? _____ Yes / _____ No

**11.** Have you been diagnosed with Asthma? _____ Yes / _____ No If Yes, When? ______________

**12.** Do you have a family history of Asthma? _____ Yes / _____ No

**13.** Have you ever been hospitalized for asthma? _____ Yes / _____ No If Yes, when was the last time? ____________________________________________________________________

**14.** How long have you resided in your current State? _____ Years / _____ Months

**15.** How long have you lived in your current residence? _____ Years / _____ Months

**16.** Did you have allergies in your previous residence or State? _____ Yes / _____ No

**17.** Are you currently taking any allergy medications? _____ Yes / _____ No

If yes, please list all medications including any over the counter (OTC) medications as well.

_____________________, _____________________, _____________________, _____________________

**18.** Are you currently taking any blood thinner medications? _____ Yes / _____ No

If yes, please list: __________________, __________________, __________________, __________________

**19.** Are you currently taking a beta-blocker for a heart condition? _____ Yes / _____ No / _____ Unsure

**20.** Are you or could you be pregnant? _____ Yes / _____ No