

ROBERT A. STRUBLE, M.D.  
ALLERGY AND IMMUNOLOGY  
1221 TRIMBLE SOUTH  
MANSFIELD, OHIO 44907-1089  
---  
TELEPHONE (419) 756-5566

## ALLERGY QUESTIONNAIRE

**Instructions:** Carefully complete in full. Accuracy and thoroughness are essential. Print all answers. Relate answers to your **own** experiences, not to previous advice on skin tests. This form must be completed prior to seeing Dr. Struble. ALL INFORMATION WILL BE CONSIDERED CONFIDENTIAL.

Name \_\_\_\_\_ Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Birth Date \_\_\_\_\_  
Occupation \_\_\_\_\_ Second Job \_\_\_\_\_

State problem(s) you wish to discuss: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

When did it begin? \_\_\_\_\_ (Year) How often does it occur? \_\_\_\_\_ (times per day, week, etc.)

Worse at night or day? \_\_\_\_\_ How long does it last? \_\_\_\_\_ (hours, days, etc.)

Circle months most severe: Jan. Feb. March April May June July Aug. Sept. Oct. Nov. Dec. ALL YEAR

What do you think makes it better? \_\_\_\_\_

What do you think makes it worse? \_\_\_\_\_

What do you think causes the problem? \_\_\_\_\_  
\_\_\_\_\_

### CIRCLE TERMS WHICH AFFECT YOUR PROBLEM.

**Irritants:** cleanser, detergent, cooking odor, perfume, powder, tobacco smoke, other smoke: \_\_\_\_\_,  
moth balls, motor fumes, paint lacquer, wax, glue, insect spray, fertilizers, ammonia, room deodorants, chemicals, Clorox,

Other: \_\_\_\_\_

**Toiletries:** soap, shampoo, shaving cream, after shave, spray deodorant, hair spray, hair tonic, hair dye, hand cream, make-up,  
toothpaste, denture cream, mouthwash, nail polish, other: \_\_\_\_\_

• **Foods:** milk, cheese, eggs, fish, shellfish, nuts, chocolate, alcohol, wine, beer, juices, spices, vegetables, strawberries, wheat  
products, very cold liquids, other: \_\_\_\_\_

• **Pets:** Which of these do you have as pets: dog, cat, bird, horse, hamster, rabbit, other: \_\_\_\_\_ Is your  
condition worse around pets? (Specify): \_\_\_\_\_

• **Drugs:** Penicillin, Sulfa, Aspirin, Over-the-Counter drugs, other: \_\_\_\_\_

**Weather:** hot, cold, humid, damp, pollution, smog, sunlight, air-conditioning, change in temperature, change in weather. \_\_\_\_\_

**New (unwashed) Clothing:** wool, silk, sweater, coat, shoes, dry-cleaned clothes, other: \_\_\_\_\_

**Contactants:** poison ivy, cut grass, cut flowers, household plants, hay, Christmas trees, plastic, fiberglass, rubber, dust, wool  
blankets, feather pillows, mattress, overstuffed furniture, rugs, rug pads, stuffed toys, furs, jewelry, shoe polish, other: \_\_\_\_\_

### CIRCLE SYMPTOMS BROUGHT ON BY YOUR PROBLEM.

**General:** nervousness, dizziness, fainting, sinus trouble, frequent colds, fatigue, other: \_\_\_\_\_

**Headache:** Where (front, back, right, left), day, night, aching, throbbing, sharp, dull, with vomiting, stuffy nose, better with sleep,  
worse with tension, spots before eyes, CAUSE: migraine, food, sinus, tension, drug, other: \_\_\_\_\_

**Skin:** rash, hives, eczema, blisters, itching, swelling, burning, stinging, redness, perspiration, dandruff, athlete's foot. Where: \_\_\_\_\_  
Worse after eating? Yes/No.

• **Eyes:** tearing, burning, itching, pain, redness, discharge, puffiness, infections, blurring of vision, glaucoma, other: \_\_\_\_\_

**Ears:** pressure, itchiness, drainage, fluid, infections, deafness, swelling, other: \_\_\_\_\_

• **Nose:** trouble smelling, stuffiness, sniffles, itching, sneezing, snoring, polyps, post-nasal drip, picking, bleeding, broken nose, previous surgery, other: \_\_\_\_\_

**Tongue:** swollen, sore, itching, coated, trouble tasting, other: \_\_\_\_\_

**Mouth:** itching of roof, repeated tonsillitis, tonsils removed, morning sore throats, bad breath, swollen lip, trouble swallowing, mouth breathing, frequent throat clearing, change in voice, other: \_\_\_\_\_

**Mucus:** thick, thin, clear, yellow, green, brown, bloody, amount per day: teaspoon, tablespoon, 1/2 cup, source of mucus: nose, lungs, throat.

• **Chest:** shortness of breath, wheeze, pain, tightness, cough, cough then wheeze, trouble walking, trouble working, trouble sleeping, heart trouble, high blood pressure, emphysema, bronchitis, pneumonia, tuberculosis, cancer, other: \_\_\_\_\_

**Stomach:** vomiting, gas, cramps, belching, diarrhea, mucus in stool, blood in stool, foul-smelling stool. Worse after eating what foods: \_\_\_\_\_

**Joints:** pain, stiffness, swelling, other: \_\_\_\_\_

**Menses: (Female Only)** regular, irregular, discharge, itch, cramps, infections, last period: \_\_\_\_\_ (date), pain.  
Are you now pregnant? Yes/No. Taking birth control pills? Yes/No.

**CIRCLE PERTINENT ITEMS AND FILL IN THE BLANKS**

**Where do you live?** room, apartment, brick house, wood-frame house, mobile home, age of house: \_\_\_\_\_

**Location:** city, suburbs, country, farm, near factory, bakery, grain storage, swamp, poultry yard, barn, other: \_\_\_\_\_

**Problem worse in:** bedroom, living room, kitchen, basement, attic, garage, indoors, outdoors, other: \_\_\_\_\_

**In what state or geographical areas is it worse?** \_\_\_\_\_

**Type of heating:** forced air, radiator, hot water, baseboard, other \_\_\_\_\_, air filter, air conditioning, (room, central).

**Problem worse when:** at home, at work, in car, in boat, exercising, at beauty shop, at school, driving in traffic, sweeping, house cleaning, making beds, around fans, mowing grass, around humidifier, around vaporizer, around open windows, around heating ducts, on windy days, taking hot or cold baths, swimming in chlorinated water, in musty places, wearing tight clothing, other: \_\_\_\_\_

**Insect bites or stings:** more than average, large swelling, weakness, sweating, shortness of breath, stuffy nose, wheezing, hives, other: \_\_\_\_\_

**Recent dental work:** fillings, root canal, tooth extraction, braces, denture, other: \_\_\_\_\_

**Marital status: (Parents' status, if patient is a child)** married, single, separated, divorced, widowed, # of children: 1, 2, 3, 4, 5, more

**Smoking habits:** Cigarettes, cigars, pipe, inhale? Yes/No. Number per day: \_\_\_\_\_ How long? \_\_\_\_\_ (years)

<b>Medications Now Used:</b>	<b>Times Used Per Day</b>
_____	_____
_____	_____
_____	_____
_____	_____

Allergy and asthma medications used in past: \_\_\_\_\_

Drugs: Marijuana, Heroin, other: \_\_\_\_\_

Childhood: breast fed, bottle fed, colic, spitting up, gas, croup, hives, eczema, hay fever, frequent colds, migraine, sinus trouble, earaches, tonsillitis, asthma, bronchitis, pneumonia, other: \_\_\_\_\_

Any reaction to immunization shots (tetanus, etc.). Yes/No. Describe: \_\_\_\_\_

Have you had previous allergy tests? Yes/No. Name of Allergist: \_\_\_\_\_

If allergy shots were given, list dates started and stopped: \_\_\_\_\_

Place age of family member having any of the following conditions in the appropriate box:

Family illnesses	Father	Mother	Brothers	Sisters	Children	Other Blood Rel.
Migraine						
Hives						
Emphysema						
Asthma						
Cystic Fibrosis						
Eczema						
Hay Fever/Sinus						
Tuberculosis						
Thyroid Disease						
Glaucoma						
Drug Allergy						

Hobbies: \_\_\_\_\_  
Husband: \_\_\_\_\_  
Wife: \_\_\_\_\_  
Children: \_\_\_\_\_  
Others at Home: \_\_\_\_\_

Seriousness of problem has caused absence from work, absence from school, inability to sleep, inability to exercise, loss of appetite, nervousness, other: \_\_\_\_\_

Unusual activities engaged in just prior to onset of symptoms: \_\_\_\_\_

Unusual food or drink just prior to onset of symptoms: \_\_\_\_\_

New environmental factors at home or at work: \_\_\_\_\_

Emotional factors: tension, worry, trouble sleeping, financial problem, marital problems, family problems, problems at work, fatigue, depression, other: \_\_\_\_\_

Do any of the above affect your problem? Yes/No. Explain: \_\_\_\_\_

List any medical condition(s) for which you have been treated: \_\_\_\_\_

List any operations you have had: \_\_\_\_\_

PHYSICIAN'S ANALYSIS OF DATA: MED resp se use

C.C. mo \_\_\_\_  
yr \_\_\_\_

EYES occ med  
qd qd clis

NOSE c+d block EARS Tm Fluid  
disch p+p ABD

CHEST cgh freq nte  
whz ca vrl  
spu ex ger

SKIN OM/SINUSITIS

Seasonal IN S F FOOD  
Perennial DRUG  
FH  
AT, AI

IMPRESSION Par Sar Con  
Asthma Rom Rsn

MED days wks mos prn

AI n/a rec call fu beg send here def prefmed

FU wk \_\_\_\_ mo \_\_\_\_ call \_\_\_\_ prn \_\_\_\_

ref \_\_\_\_\_ xray \_\_\_\_\_ lab \_\_\_\_\_