ALLERGY QUESTIONNAIRE

Does the student have any allergies (*medical, food, insect; environmental, etc*)?

◯ Yes ◯ No

If **YES**, please briefly identify and describe the reaction.

When did the reaction occur? (*Date and time of the day*)

Length of the time from the exposure (or sting/ injection) until the onset of symptoms:

How long did your symptoms last?

Please check any of the following symptoms you had with your reaction:

__ shortness of breath

__wheezing or chest tightness

__dizziness or loss of consciousness

__abdominal cramping, diarrhea/ vomiting

__flushing

__hoarseness or change in voice

__tongue swelling

__throat tightness or trouble swallowing

Did you get medical attention? ◯ Yes ◯ No

If **YES**: was it from _Emergency Room _Urgent Care _Clinic _911/Medic

TREATMENT?

Have you ever had an episode of anaphylactic shock before?

◯ Yes ◯ No

Do you have a current EpiPen?

◯ Yes ◯ No

Complete this section only for: CHEST or ASTHMA SYMPTOMS

1) Check all that apply **and circle** the ones that bother you the most:

__shortness of breath __wheezing __chest pain or tightness

__coughing up blood __recurrent or chronic cough – if yes, is the cough:

◯ wet/productive ◯ dry

2) When did your symptoms **first** begin? _____ When, if so, did they **get worse**? _____

3) Are your symptoms: seasonal* all year long all year long, with seasonal* worsening?

** Circle **worst months**:*

Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec

4) **How often** do you have symptoms?

◯ 2 or less times a week ◯ once a day ◯ 3–6 times a week ◯ throughout the day

5) Do these symptoms **disturb your sleep**?

Yes* No

*If yes, how often?

__2 or less times a month __3–4 times a month

__2–6 times a week __every night

6) Do your symptoms ever **interfere with exercise** or **daily activities**? **Yes*** No

* If yes, what activity? _____

7) Have your symptoms forced you to **miss work** or **school**?

(Circle which one) **Yes*** No

* If yes, how many times in the past 12 months? _____

8) Have your symptoms caused you to go to the **Emergency Room** or **Urgent Care**?

Yes* No * If yes, how many visits in the past 12 months? _____

9) Have your symptoms caused you to be **admitted** overnight to the hospital?

Yes* No

* If yes, how many times? _____
* Were you ever in the Intensive Care Unit? Yes No
* Have you been intubated or on a ventilator? Yes No

10) Have you ever needed treatment with an oral or injectable **steroid**? *(e.g. prednisone*)
Yes* No
* If yes, when was your last course of steroids?

11) Check the things that make your **chest symptoms worse**:

Irritants	**Infections**	**Weather**	**Medicine**	**Allergens**	**Location**	**Other**
_smoke _fumes/car _exhaust _air pollution _strong odors or perfumes	_colds or flu _sinus infections	_cold air _weather changes _heat	_aspirin _non-steroidal anti-inflammatory agents *(e.g. Motrin, Advil, Aleve)*	_grass _dust/vacuuming damp or musty areas _animals, If yes, specify: _____	_outdoors _indoors _home _daycare _school work: _____	_exercise _emotion/ stress _laughing other: _____

12) you ever had pneumonia? **Yes*** No * If yes, how many times? _____

13) Have you had a **chest X-ray** since your symptoms began? **Yes*** No
* If yes, when? _____

14) Do you have symptoms of **heartburn or acid reflux**? **Yes*** No
* If yes, how often? _____

If you've been prescribed albuterol or have asthma, please answer the following questions:

1) How many **puffs** of albuterol do you use **per day**? _____
2) How many **canisters** of albuterol do you use **each month**? _____
3) Do you use a **spacer** with your inhalers? Yes No
4) Do you monitor your **peak flows**? **Yes*** No

* If yes, what is your **personal best peak flow**? _____
* What has been the **range** of your peak flow readings over the past 2 weeks?
_____