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