GRANGER MEDICAL CLINIC

Allergy Clinic Follow Up Questionnaire

Name: _____ Date: _____ MRN: _____

Any new medical problems (heart disease, lung disease, blood pressure, etc.)? ☐ Yes ☐ No
Any changes in your environment (pets, job, quit smoking, move, mold, etc.)? ☐ Yes ☐ No
Any new medical problems in your family? ☐ Yes ☐ No
Any new medications? ☐ Yes ☐ No
If you answered yes, to any of the above, please explain: _____

_____

Please check any of the following problems you are experiencing:

Allergy:	☐ New Allergies	☐ Immune-Deficiency		
Ears, Nose, and Throat:	☐ Congestion ☐ Itchy throat	☐ Runny nose ☐ Sore throat	☐ Nose bleeds ☐ Earaches	
Endocrine:	☐ Hot flashes	☐ Cold or heat intolerance		
Eyes:	☐ Itching	☐ Changes in vision		
General:	☐ Unintentional weight loss	☐ Chronic fevers	☐ Increased fatigue	
Heart:	☐ Chest pain	☐ Abnormal heart beat	☐ Fainting spells	
Hem/Lymph:	☐ Persistent swollen nodes	☐ Easy bruising		
Lungs:	☐ Shortness of breath	☐ Chest tightness	☐ Cough	☐ Wheeze
Psychiatric:	☐ Depression	☐ Anxiety	☐ Voices	
Skin:	☐ New chronic rash	☐ Chronic itching	☐ New blisters	

For the following sections, please fill out only those sections that pertain to you.

Asthma

How often have you woken at night with a cough or wheeze in last 30 days? #___ per ☐ Week ☐ Day
How often have you needed albuterol, except for exercise, in last 30 days? #___ per ☐ Week ☐ Day
How often have you taken your controller asthma medicine in last 30 days? #___ per ☐ Week ☐ Day
How long ago did you last need prednisone for your asthma? #___ ☐ Weeks ☐ Months ☐ Years
How long has it been since you were seen urgently for asthma? #___ ☐ Weeks ☐ Months ☐ Years
What are your peak flows and how do they compare to your usual best? #___ ☐ Same ☐ Better ☐ Worse
What asthma medications do you take regularly? _____
What asthma medications do you take as needed? _____

Allergic Nose/Eye Symptoms

How are your allergies?	☐ Great	☐ Good	☐ Fair	☐ Poor	☐ Terrible
What are your most bothersome allergies?	☐ Eyes	☐ nose	☐ rash	☐ other _____	
What do you take/use for allergies?	☐ Pill	☐ Nose spray	☐ eye drop	☐ wash	
How often do you take your medication?	☐ Never	☐ daily	☐ 2x Day	☐ as needed	
Are you on shots?	☐ Yes	☐ No			
If yes, have they helped?	☐ Yes	☐ No			
Have you had any reactions?	☐ Yes	☐ No			

What allergy medications do you take? _____
What types of reactions have you had? _____

Chronic Eczema

How is your eczema? ☐ Great ☐ Good ☐ Fair ☐ Poor ☐ Terrible

What symptoms do you have with your eczema? ☐ Sleep problems ☐ itching ☐ redness ☐ infections

What treatment are you on? ☐ Baths ☐ Wraps ☐ Lotions ☐ medicated creams

How often do you use eczema therapies? ☐ Never ☐ Daily ☐ Weekly ☐ Monthly ☐ Needed

What part of your body is most affected? ☐ Face ☐ arms ☐ legs ☐ hands
☐ chest ☐ neck ☐ Other _____

What eczema medication cream do you use? _____

Chronic Urticaria/Angioedema (hives/swelling)

How are your hives doing now? ☐ Great ☐ Good ☐ Fair ☐ Poor ☐ Terrible

Do hives interfere with daily activity? ☐ Yes ☐ No How? _____

Do you currently have hives? ☐ Yes ☐ No Where? _____

Do you need sedating antihistamines? ☐ Yes ☐ No

Do you need prednisone for control? ☐ Yes ☐ No

Please list the medications you take for your hives: _____

Food Allergies (answer for each food type)

Food Type 1: _____

Type of reaction: ☐ Anaphylaxis ☐ hives ☐ eczema ☐ wheezing ☐ itchy mouth/throat

When was your last exposure? #____ ☐ Days ☐ Weeks ☐ Months ☐ Years

What kind of exposure was it? ☐ Skin ☐ Mouth ☐ Ingestion

How much food did you ingest? ☐ Unknown ☐ Pea size ☐ Golf ball size ☐ Baseball size ☐ other _____

What type of reaction did you have? ☐ Anaphylaxis ☐ Hives ☐ Eczema ☐ Wheeze
☐ itchy mouth ☐ other _____

What treatment did you give/take? ☐ None ☐ Benadryl ☐ Zyrtec ☐ EpiPen ☐ ER ☐ Other _____

Food Type 2: _____

Type of reaction: ☐ Anaphylaxis ☐ hives ☐ eczema ☐ wheezing ☐ itchy mouth/throat

When was your last exposure? #____ ☐ Days ☐ Weeks ☐ Months ☐ Years

What kind of exposure was it? ☐ Skin ☐ Mouth ☐ Ingestion

How much food did you ingest? ☐ Unknown ☐ Pea size ☐ Golf ball size ☐ Baseball size ☐ other _____

What type of reaction did you have? ☐ Anaphylaxis ☐ Hives ☐ Eczema ☐ Wheeze
☐ itchy mouth ☐ other _____

What treatment did you give/take? ☐ None ☐ Benadryl ☐ Zyrtec ☐ EpiPen ☐ ER ☐ Other _____

Food Type 3: _____

Type of reaction: ☐ Anaphylaxis ☐ hives ☐ eczema ☐ wheezing ☐ itchy mouth/throat

When was your last exposure? #____ ☐ Days ☐ Weeks ☐ Months ☐ Years

What kind of exposure was it? ☐ Skin ☐ Mouth ☐ Ingestion

How much food did you ingest? ☐ Unknown ☐ Pea size ☐ Golf ball size ☐ Baseball size ☐ other _____

What type of reaction did you have? ☐ Anaphylaxis ☐ Hives ☐ Eczema ☐ Wheeze
☐ itchy mouth ☐ other _____

What treatment did you give/take? ☐ None ☐ Benadryl ☐ Zyrtec ☐ EpiPen ☐ ER ☐ Other _____

Vocal cord dysfunction (VCD)

Is the speech therapy helping? ☐ Yes ☐ No

Do you feel like you have better understanding of when you have VCD vs. asthma? ☐ Yes ☐ No

Do you use peak flows to tell the difference between VCD and asthma? ☐ Yes ☐ No