Allergy Impact Questionnaire

OFFICE STAFF ONLY: ICD-10 CODES FOR PATIENT: _____: _____ : _____ : _____ : _____

Patient's Name: _____ D.O.B. ____/____/____ Date of Service: ____/____/____

1. Do you think you suffer from Allergies? ☐ Yes ☐ No

2. Are the symptoms year-round or seasonal? ☐ Year Round ☐ Seasonal

3. How long do your symptoms last during an allergy flare up?
☐ > than 7 days ☐ < 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?** ☐ AM ☐ PM ☐ All Day

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**? _____

14. How long have you lived in Texas? ____ 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 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