WHOLE LIFE HEALTH CENTER, LLC
PAIN CENTER OF GWINNETT

Allergy Questionnaire

Patient Name: ______________________ **Date:** ______________________

Address: ______________________ **Date of Birth:** ______________________

City, State, Zip: ______________________ **Home#:** ______________________

Gender (circle one): **MALE** **FEMALE** **Cell#:** ______________________

Primary Care Physician: ______________________ **Referring Physician:** ______________________

Email: ______________________

Although your history and symptoms are very important in our analysis of your condition, it is also important for us that you understand:

- *We do not treat symptoms or diseases.*
- *Allergy is not a disease, rather a condition.*
- *A symptom is an attempt by your body to tell you something.*
- *We will attempt to find the underlying cause.*
- *We do not use drugs in this program.*
- *There is no single "healthy" diet that will work for everyone.*
- *Just because food is considered "healthy", does not mean it is "healthy" for you.*
- *Your diet consists of everything you **eat, drink, rub on your skin, or inhale**.*
- *Our procedures are safe and painless.*

Please list the four main important complaints in order of importance:

1. ______________________
2. ______________________
3. ______________________
4. ______________________

Current Medications / Vitamins taking:

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History of illness and treatments:

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AGE WHEN SYMPTOMS WERE FIRST OBSERVED

Infant (Age 0-2) Child (Age 3-5)
Child (Age 6-12) Adolescent (Age 13-18)
Adult (Age 19-25) Adult (Age 26-40)
Adult (Age 41 and over)

DID YOU SUFFER FROM ANY TYPE OF PHYSICAL, CHEMICAL OR EMOTIONAL TRAUMA JUST BEFORE YOUR SYMPTOMS WERE FIRST OBSERVED? ______________________________

HAVE YOUR SYMPTOMS EVER GONE AWAY FOR ANY PERIOD OF TIME? ________________

PREVIOUS DIAGNOSIS OF ALLERGY

Yes and allergy shots helped Yes but allergy shots did not help
Yes and medication helped Yes but medication did not help
None

FAMILY MEMBERS WITH ALLERGIC SYMPTOMS

Mother Father
Brother/Sister Grandparents
Son/Daughter Spouse
None

FREQUENCY & SEVERITY OF ALLERGY SYMPTOMS

Constant/Chronic with little change Present most of the time
Present part of the time Present rarely

Prevents some normal activities Considerable interference with normal life
Slight interference with normal life No interference with normal life

SYMPTOMS ARE WORSE

- ☐ Outdoors and better indoors
- ☐ At nighttime
- ☐ In the bedroom or when in bed
- ☐ During windy weather
- ☐ During wet or damp weather
- ☐ When the weather changes
- ☐ During known pollen seasons
- ☐ In certain rooms or buildings
- ☐ When exposed to tobacco smoke
- ☐ With yard work, cut grass, leaves, hay or barns
- ☐ When sweeping or dusting the house
- ☐ In areas with mold or mildew
- ☐ In air conditioning
- ☐ In fields or in the country
- ☐ Tobacco smoke bothers me more than anything else

SYMPTOMS ARE BETTER

- ☐ After shower or bath
- ☐ In air conditioning
- ☐ Indoors
- ☐ During or after physical activity

☐ After taking antihistamines ☐ With allergy shots

What makes you feel better? ______________________________

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ANIMALS, INSECTS AND BIRDS THAT CAUSE SYMPTOMS ON EXPOSURE

☐ Dogs ☐ Cats ☐ Rodents (mice, guinea pigs, etc.)
☐ Horses or Cattle ☐ Rabbits ☐ Birds or Feathers
☐ Bees ☐ Other ______________________________
☐ None

FOOD RELATED SYMPTOMS

☐ Symptoms flare 5-60 minutes after meals
☐ The smell or odor of some foods increases symptoms
☐ Some foods cause swelling of the mouth or tongue
☐ Some foods cause upset stomach or vomiting
☐ Symptoms occur with restaurant salad bars or Asian foods
☐ Symptoms occur with any regularly eaten food
☐ Preservatives, additives or food coloring increase symptoms
☐ Some foods are craved or addictive
☐ Some foods cause nasal symptoms
☐ Some foods cause rashes or hives
☐ Some foods cause diarrhea
☐ Some foods cause headaches
☐ Some foods cause asthma
☐ No problem with foods

FOODS THAT CAUSE SYMPTOMS FROM <u>ONE HOUR TO THREE DAYS</u> AFTER EXPOSURE

☐ Eggs ☐ Milk ☐ Beef
☐ Corn ☐ Wheat ☐ Soybean
☐ Peanut ☐ Pork ☐ Fish
☐ Shellfish ☐ Orange or other citrus ☐ Potato
☐ Tomato ☐ Yeast ☐ Chocolate
☐ Coffee or Tea ☐ Other ______________________________
☐ None

CHEMICALS THAT CAUSE SYMPTOMS

☐ Insecticides & pesticides
☐ Perfumes & cosmetics
☐ Stove or furnace emissions
☐ Chemicals in the workplace
☐ Newsprint
☐ None
☐ Paints & household cleaners
☐ Gasoline or automobiles exhaust
☐ The smell of new fabrics or fabric store
☐ Laundry detergent
☐ Other: ______________________________

WHEN ARE YOUR SYMPTOMS WORSE ☐ Year around

☐ January ☐ February ☐ March ☐ April
☐ May ☐ June ☐ July ☐ August
☐ September ☐ October ☐ November ☐ December

MEDICATIONS

Do you take any of the following medications on a regular basis?

☐ Antihistamines (Benadryl, Actifed, Chlortrimeton, Tylenol Sinus, Tylenol Sleep, Dimetapp,Drixoral, Trimalin, Atarax, Claritin, Allegra, Zyrtec, etc)

☐ Bronchodilators (Albuterol, Ventolin, Proventil, Serevent, or OTS's such as Primatine Mist, etc)

☐ Steroid Inhalers (Asmacort, Flovent, Pulmicort, Beclovent, Aerobid, Advair, etc)

☐ Nasal Steroids (Beconase, Flonase, Nasacort, Rhinocort, etc)

☐ Medications that affect the immune system (Prednisone, Imuran, Methotrexate, Cellcept, Cyclosporine, Tacrolimus, etc)

☐ Chemotherapy

Please list any medications that you are currently taking: ____

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SMOKING

Do you presently smoke? ☐ Yes ☐ No If yes, average number of cigarettes per day ___________

If yes, at what age did you start? ____

Does anyone smoke in your home? ☐ Yes ☐ No

PREVIOUS ALLERGY EVALUTION

Have you ever seen an allergist? ☐ Yes ☐ No

Have you had allergy skin testing? ☐ Yes ☐ No

Did you have any positive reaction? ☐ Yes ☐ No

If yes, please list positive allergens (include any medications) ______________________________

Have you ever received allergy injections? ☐ Yes ☐ No

WORK ENVIRONMENT

What is your occupation? ____

Are you exposed to chemicals or strong odors at work? ☐ Yes ☐ No

If yes, briefly explain ____

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Are you symptoms worse while at work? ☐ Yes ☐ No

If yes, briefly explain ____

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Check all that apply

Stubborn Weight

- ❑ Craves refined carbohydrates
- ❑ Frustrating stubborn weight
- ❑ History of low-calorie diets
- ❑ Fluid retention
- ❑ History of birth control pills
- ❑ History of Hormone Replacement Therapy
- ❑ High protein diets don't work
- ❑ Lack of willpower
- ❑ Can't lose weight despite exercise

Menstrual (female only)

- ❑ PMS
- ❑ Irregular periods
- ❑ Ovarian Cysts
- ❑ Heavy bleeding during menstruation
- ❑ Fibrocystic breasts

Menopause (female only)

- ❑ Hot flashes
- ❑ Night Sweats
- ❑ Vaginal Dryness
- ❑ Leaky bladder
- ❑ Frequent urination at night
- ❑ Bone loss/osteoporosis

Blood Sugar

- ❑ History of diabetes in family
- ❑ Cravings for sweets, refined carbohydrates
- ❑ Tired at 3:00 pm (afternoon)
- ❑ Insomnia (difficulty sleeping)
- ❑ Acne and skin problems
- ❑ Lack of energy
- ❑ Depression
- ❑ Anxiety
- ❑ Numbness or tingling in finger tips or toes
- ❑ Eye sight getting worse
- ❑ Excessive thirst
- ❑ Gets irritable or shaky when hungry

Thyroid

- ❑ Fatigue
- ❑ Intolerance to cold
- ❑ Cold hands or feet
- ❑ Sluggish elimination or constipation
- ❑ Mental sluggishness or lethargy
- ❑ Hair loss
- ❑ High cholesterol
- ❑ Ridged nails (vertical-up and down) or brittle nails
- ❑ Weight (sluggish)

Digestion/Kidney

- ❑ Bad breath

- ❑ High blood pressure
- ❑ High cholesterol
- ❑ Stomach bloats when eating wheat or sugar
- ❑ Skin problems
- ❑ Burning feet
- ❑ Pain between shoulder blades
- ❑ Intestinal gas
- ❑ Coated tongue (white film)
- ❑ Indigestion, acid reflux
- ❑ Irritable bowel problems
- ❑ History of antibiotics
- ❑ Toe nail fungus
- ❑ Headaches or Migraines
- ❑ Painful joints
- ❑ Right shoulder pain or tightness
- ❑ Itchy private parts

Prostate (male only)

- ❑ Urination difficulty or dribbling
- ❑ Night urination frequency
- ❑ Enlarged prostate

Adrenal

- ❑ Out of breath when walking up stairs
- ❑ Dizziness
- ❑ Excessive facial hair-female
- ❑ Fatigue during the day
- ❑ Difficulty getting out of bed in the morning
- ❑ Waking up in the middle of the night
- ❑ Arthritis or stiff and painful joints
- ❑ Nervousness
- ❑ Fluid retention
- ❑ Swollen ankles
- ❑ Allergies
- ❑ Asthma
- ❑ Craving salt (chips, pretzels)
- ❑ Muscle cramps, worse during exercise
- ❑ Dull pain in chest or radiating in left arm

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ANY ADDITIONAL INFORMATION YOU WOULD LIKE US TO KNOW? ____________________

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ANYTHING ELSE YOU WOULD LIKE TO ASK? ______________________________

Patient Signature ______________________________