BOULDER VALLEY
Ear, Nose & Throat
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Allergy History Questionnaire

Name: _____ DOB:_____Today's Date:_____

Allergies:_____

Current medications:_____

_____

Check all that apply below and fill in information as needed.

Fill in your typical allergy symptoms:

- ☐ Eyes:
- ☐ Ears:
- ☐ Nose:
- ☐ Mouth:
- ☐ Skin:
- ☐ GI/GU:
- ☐ Other:

Symptoms are:

- ☐ Continuous
- ☐ Variable
- ☐ Year round
- ☐ Seasonal
- ☐ Other:

Symptoms worse:

- ☐ Morning
- ☐ Night
- ☐ Don't change
- ☐ Outside
- ☐ Indoors

Health:

- ☐ Asthma
- ☐ History of Anaphylaxis
- ☐ Fainting

Family history of allergies:

- ☐ Mother
- ☐ Father
- ☐ No
- ☐ Uncertain

Pregnant or chance of pregnancy?

- ☐ Yes
- ☐ No

House:

Select Housing Type

Age ☐

- ☐ History of Flood or fire
- ☐ Carpet

Pets:

- ☐ Dog
- ☐ Cat
- ☐ Horse
- ☐ Other:

Do you currently smoke?

- ☐ Yes
- ☐ No

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