IC Laser Eye Care

Allergy Questionnaire

Name:_____ D.O.B._____Age_____

Date_____ M_____ F_____ Occupation_____

Do You have any of these systems? (Check all that apply)

____Cough	____Runny Nose	____Nasal Congestion
____Wheezing	____Itchy Nose	____Shortness of breath
____Chest tightness	____Itchy/watery eyes	____Sneezing
____Postnasal drip	____Ear Infections	____Blocked ears
____Phlegm	____Sinus infections	____Hives/Swelling
____Headaches	____Snoring	____Fatigue
____Eczema	____Nasal Polyps	____Poor Sense of smell
____Other_____		

Check any of the following that seems to trigger (or cause) your systems to bother you.

____Grass	____Cats	____Dogs
____Hay	____Odors	____Perfumes
____Mold/Mildew	____Leaves	____Household dust
____Exercise	____Smoke	____Weather Changes
____Latex	____Humidity	____Aerosol sprays
____Cosmetics	____Insecticides	____Pollution

When are your systems worse?

		____Year Round	
____January	____February	____March	____April
____May	____June	____July	____August
____September	____October	____November	____December

Have you been skin tested? ____Yes____No Results_____

_____

Have you ever had allergy injections? ____Yes ____No When?_____
Have you received Cortisone(prednisone, methylprednisolone, etc) ____Yes ____No

Environmental Survey
Do you live in the _____**City** _____ **Suburbs** _____**Rural Area**
Do You have a basement?____Yes____No
Do you smoke or anyone in your home?____Yes ___No
Is your house built on a slab? ___Yes __No
Heating system is in your home?____**Hot Air** __**Radiator**___**Electric**___**Baseboard**
Do you have a **Humidifier**__Yes__No **Air Cleaner** __Yes __No **Fireplace** __Yes__No
Do you have Pets? How Many? ____**Dogs** ____**Cats** ____**Birds** ___**Other**_____

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