University of Maryland
University Health Center

Allergy Clinic Questionnaire

Name: _____ University ID: _____

Age: _____ Sex: _____ Phone: _____ Cell: _____ Date: _____

1. What is the main allergy symptom under treatment? Check one.
   ❑ Hay Fever ❑ Skin Problem ❑ Asthma ❑ Headache ❑ Other: _____

2. Do you have asthma (wheezing) now? ❑ Yes ❑ No

3. Have you ever suffered from asthma in the past? ❑ Yes ❑ No

4. Does your allergist give you any medications other than your serum? ❑ Yes ❑ No
   If YES, please list: _____

5. Have you ever experienced a bad reaction to any allergy injection? ❑ Yes ❑ No

6. How long have you been taking allergy injections? _____ Years _____ Months

7. When did you last see your allergist for a check-up? _____ Years _____ Month

8. Do you regularly take any medications prescribed by any other physician(s)? ❑ Yes ❑ No
   If YES, please list: _____

9. Are you now under the care of a non-allergist for the management of your allergies? ❑ Yes ❑ No

10. Do you have any food allergies? ❑ Yes ❑ No
    If YES, please list: _____

11. Do you have any other allergies not under treatment? ❑ Yes ❑ No
    If YES, please list (e.g., medicines, insect bites): _____

12. Is there a history of allergy in other family members? ❑ Yes ❑ No
    If YES, please check: ❑ Hives ❑ Itching ❑ Asthma ❑ Other
    If OTHER, please list: _____

_____

_____

Patient's Signature Date

Reviewed 8.14