University of Nebraska Lincoln

ALLERGY HISTORY QUESTIONNAIRE
(NEW PATIENT)

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name *(Last, First, M.I.)* ____________________ Date of Birth ____________

PERSONAL HEALTH HISTORY

Do you have an EpiPen? ☐ Yes ☐ No

Have you ever been diagnosed with Asthma? ☐ Yes ☐ No

Have you ever received allergy injections? ☐ Yes ☐ No

If yes, when: ____________

Please list current medications

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Please list current allergies including medication, environmental and food

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Allergy Physician ____________________

What was the date of your last allergy physician visit? ____________________

COMPLETE THE FOLLOWING IF YOU HAVE EVER HAD ALLERGY INJECTIONS

Have you ever had any local reactions after an allergy injection? ☐ Yes ☐ No

Previous treatment advised by your physician for local reactions

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- ☐ Itching localized to area of injection
- ☐ Redness localized to the area of injection
- ☐ Swelling localized to the area of injection
- ☐ Other local reactions ____________________

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Have you ever had any systemic reactions after an allergy injection? ☐ Yes ☐ No

Previous treatment advised by your physician for systemic reactions

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Skin
- ☐ Allergic hives
- ☐ Sudden onset of swelling of eyes, hands and/or feet
- ☐ Generalized itching
- ☐ Sudden redness of skin (flushing)

Other
- ☐ Difficulty swallowing
- ☐ Abdominal pain
- ☐ Nausea
- ☐ Diarrhea
- ☐ Excessive sweating
- ☐ Red eyes moderate to severe

Cardiovascular
- ☐ Low blood pressure
- ☐ Chest discomfort
- ☐ Dizziness
- ☐ Headache

Respiratory
- ☐ Runny nose
- ☐ Nasal Stuffiness
- ☐ Sneezing
- ☐ History of shortness of breath
- ☐ Wheezing
- ☐ Cough

☐ Other systemic reactions ____________________

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