Patient Allergy Screening Questionnaire

Please help us understand the extent of your allergies and how it impacts your daily life. Select your response below and write the number(s) corresponding with your answer on the line.

Do you have allergies?

_____ Not sure (0)
_____ Yes, self-diagnosed (1)
_____ Yes, diagnosed by medical provider (2)
_____ Yes, self-diagnosed & confirmed by medical provider (2)

What kind of allergy or related conditions do you have? (Include all that apply)

_____ Seasonal pollen allergy like trees, grass, weeds (1)
_____ Year-round airborne allergy like mold, animals, dust mite (1)
_____ Food allergy (2)
_____ More than one food allergy (1)
_____ Asthma (2)
_____ Chronic cough lasting weeks or longer (2)
_____ Wheezing/shortness of breath (2)
_____ Eczema/chronic skin rashes (2)
_____ Hives/angioedema (swelling in skin/mucous membranes) (3)
_____ Sinusitis/chronic sinus infections two or more times/year (2)
_____ Chronic ear infection two or more times/year (2)
_____ Eosinophilic esophagitis (3)
_____ Itchy/red/watery eyes (1)
_____ Anaphylaxis (4)
_____ Stinging insects (1)
_____ Allergy to medications (1)

How are you currently treating your allergies? (Include all that apply)

_____ Over-the-counter medications like antihistamines, skin creams, etc. (1)
_____ Prescription medications like inhalers or topical steroids (2)
_____ Biologics like Dupixent, Xolair, Nucala, Eucrisa (3)
_____ Allergy Immunotherapy — shots, drops or tablets (1)
_____ Stopped allergy immunotherapy due to reactions (2)
_____ Avoiding allergy triggers using air filters, pillow/mattress covers, etc. (2)
_____ Other _____

During the past seven days, how much did your allergy-related problem affect your productivity while you were working? Think about days you were limited in the amount/kind of work you could do, days you accomplished less than you'd like, or could not do work as carefully as usual.

_____ Not troubled (0)
_____ Hardly troubled at all (1)
_____ Somewhat troubled (1)
_____ Moderately troubled (2)
_____ Quite a bit troubled (2)
_____ Very troubled (3)
_____ Extremely troubled (3)
_____ N/A (0)

During the past seven days, how much did your allergy-related issues affect your ability to do regular daily activities other than work at a job or school? By regular activities, we mean activities like housework, shopping, childcare, exercise, studying, etc.

_____ Not troubled (0)
_____ Hardly troubled at all (1)
_____ Somewhat troubled (1)
_____ Moderately troubled (2)
_____ Quite a bit troubled (2)
_____ Very troubled (3)
_____ Extremely troubled (3)
_____ N/A (0)

Total Score (for practice use only) _____

FOR PROVIDERS — Allergy Screening Questionnaire Key

The Allergy Screening Questionnaire is intended to provide you with an additional data point to help assist you in determining your patient's allergic disease and level of severity. Once the patient has completed the screening questionnaire, add the numbers corresponding to the patient's answers. Use the total point value as a guide to the patient's allergic severity level from the key below.

Scoring Key

0-9: Patient notes that allergy has minimal impact on health/lifestyle. Most symptoms can be well controlled through symptom-relieving medication and lifestyle modifications, however some may benefit from immunotherapy for persistent issues.

10-15 points: Patient notes moderate issues relating to allergic symptoms, and may benefit from allergy testing to determine triggers and potential treatment to modify disease using sublingual allergy immunotherapy.

16+ points: Patient notes a high number of symptom and quality of life issues that could benefit from further assessment and treatment. Recommended next steps include allergy testing to determine specific allergic triggers that may benefit from disease-modifying sublingual allergy immunotherapy.