Allergy Screening Questionnaire

Please help us understand the extent of your allergies and how it impacts your daily life.

1 **Do you have allergies?** (Select one)

☐ Not that I know ☐ Yes, Self-Diagnosed ☐ Yes, Confirmed by Medical Provider

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

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

3 **How are you currently treating your allergies?** (Select all that apply)

☐ Over-the-counter medications (antihistamines, skin creams, etc.)
☐ Prescription medications (inhalers, topical steroids, oral medications, etc.)
☐ Biologics (Dupixent®, Xolair®, Nucala®, Eucrisa®)
☐ Allergy Immunotherapy -- shots, drops or tablets
☐ Avoiding allergy triggers using air filters, pillow/mattress covers, etc.

4 **During the past seven days, how much did allergy-related issues affect your productivity?**

	Not Troubled	Rarely Troubled	Somewhat Troubled	Very Troubled	NA
Work	☐	☐	☐	☐	☐
Non-Work Activities	☐	☐	☐	☐	☐

Name _____ Date _____

Or Take the Allergy Questionaire Online here ▷

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