



ALLERGY QUESTIONNAIRE

This allergy questionnaire lists symptoms and other factors most commonly found in people suffering from some form of allergy. Filling out and scoring this questionnaire should help you and your physician decide if you have an allergy problem, therefore determining whether any allergy testing needs to be done. For every "yes" answer, circle the corresponding "Point Score" number. Total your score and record it in the box at the end of the questionnaire.

Name: _____ Date: _____

Date of Birth: _____

POINT SCORE

- | | |
|---|---|
| 1. Do you have any hay fever symptoms, such as sneezing, watery nasal drainage and nasal itching? | 4 |
| 2. Do you have chronic nasal congestion or postnasal drip? | 3 |
| 3. Do you have sinus problems, frequent colds or headaches? | 2 |
| 4. Do your eyes itch, water, get red or swell? | 4 |
| 5. Do you have asthma, a tight chest or chronic cough? | 1 |
| 6. Do you have skin problems, such as eczema, hives or itching? | 2 |
| 7. Do you have indigestion, bloating, diarrhea or constipation? | 1 |
| 8. Do you have chronic fatigue or tiredness? | 2 |
| 9. Are your symptoms seasonal, or do they worsen when seasons change? | 4 |
| 10. Do your symptoms change when you are indoors/outdoors? | 3 |
| 11. Are your symptoms worse in parks or grassy areas? | 4 |
| 12. Are your symptoms worse in the morning or after waking? | 2 |
| 13. Do your symptoms worsen when in contact with dust, while vacuuming, etc.? | 4 |
| 14. Are your symptoms worse around animals? | 2 |
| 15. Do you have any close relatives with allergies? | 4 |

Total Score _____

If your total score is:

- Under 8: Allergy is unlikely.
- 8-12: Allergy is possible.
- 12-20: Allergy is probable.
- Over 20: Allergy is very likely.