NAME:_____
DATE:_____

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 the "yes: answer, circle the "Point Score". Total your score and record it in the box at the end of the questionnaire.

	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 and/or post nasal drip?	3
3. Do you have sinus problems, frequent colds, headaches?	2
4. Do your eyes itch, water, get red, and/or swell?	4
5. Do you have asthma, tight chest, and/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 you 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 awaking?	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?	3

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

Total Score_____