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QUESTIONNAIRE ON ALLERGIES

The symptoms that your child is experiencing may be caused by an allergy. It is possible that your child could be hypersensitive to certain substances in his/her surroundings. This questionnaire may help to identify those substances, which could be in your home, your child's environment or outside. — Please read the following questions thoroughly and answer them as detailed and precisely as possible.

Patient's name ______________________________

Person completing this questionnaire: ○ mother ○ father other person ____________

What symptoms have caused you to seek medical attention? ______________________

Do or did the following symptoms occur:

		first appearance
(1)	obstructive bronchitis	____
(2)	croup cough	____
(3)	infant eczema	____
(4)	shortness of breath, problems in breathing, asthma	____
(5)	shortness of breath during effort	____
(6)	cough, dry cough, rpt. bronchitis	____
(7)	coughing up slime	____
(8)	sneeze attacks	____
(9)	impaired breathing through nose, chronic congestion of nose	____
(10)	inflammation of sinuses	____
(11)	itchy/watery eyes, conjunctivitis	____
(12)	nettle-fever, urticaria	____
(13)	swelling and/or itching of lips/throat; sore throat (esp. after meals)	____
(14)	swelling of eyes/eyelids	____
(15)	skin itch, eczema, neurodermitis	____
(16)	migraine, headaches	____
(17)	stomach/intestine complaints, e.g. frequent diarrhea, stomach aches	____
(18)	frequent "colds"	____
(19)	inflammation of throat/tonsils	____
(20)	circulatory problems, dizziness, vertigo	____

others: ______________________

Does a relative suffer from any of the above mentioned symptoms: (Please fill in number(s))
○ no ○ mother ________ ○ father ________ other person ________: ________

When do your child's symptoms appear:
- ○ varying, not depending on certain seasons
- ○ throughout the whole year
- ○ throughout the whole year, but esp. during following months ____________
- ○ during the following seasons ________
- ○ during certain activities

  ____

Where do your child's symptoms appear:
- ○ in the house, in the following rooms ____________
- ○ in the bed, in the bedroom
- ○ at relative's, friends'
- ○ on meadows, fields
- ○ somewhere else ____________
- ○ at certain places: ____________

Are the symptoms intensified by:
- ○ changes in weather
- ○ coldness
- ○ sun, warmth, drought, wind
- ○ mowing meadows
- ○ near hay or straw
- ○ cleaning of animal cages or stables
- ○ in stables, in the zoo, in the circus
- ○ in humid regions or rooms
- ○ at the beginning of heating period (September/October)
- ○ in dusty rooms
- ○ sweeping, dusting, vacuuming
- ○ making the beds or going to bed
- ○ hot smells, steams, sprays, smoke
- ○ airway infections
- ○ contact with animals

  ____
- ○ doing hobbies

  ____
- ○ physical effort

Do the symptoms completely or partially disappear (for a short time):
○ no ○ near the sea ○ in the high mountains ○ in the hot summer
○ on rainy days ○ at the weekend ○ at other activities: ____________________

Is there any contact with animals:
○ no ○ dog ○ cat ○ horse ○ guinea-pig ○ rabbit ○ budgerigar ○ parrot
○ sheep ○ pig ○ cattle ○ golden hamster ○ mouse, rat
○ canary ○ pigeon ○ goat ○ poultry ○ other ____________________

You are living in:
○ city ○ town ○ village
○·apartment ○ house with a garden
○ farm
○ old building ○ new building
○·central heating ○ stove heating
Your home is:
○ dry ○ damp ○ moldy

Your child's mattresses are made of:
○·foamed material ○ spring-interior
○ horsehair ○ kapok ○ seaweed
○ other: ____________________
Your blankets are made of: ○ feathers
○ down ○ animal wool ○ silk
○ synthetic fiber ○ other: __________

Does anybody smoke in the vicinity of your child? ○ yes ○ no

Do you have: ○ garden ○ indoor plants/flowers ○ carpets ○ wall hanging
○ hides, furs, hunting trophies

Is there indigestibility or dislike of: ○ milk ○ eggs ○ cheese ○ curd cheese ○ cocoa
○ chocolate ○ honey ○ fruit juice ○ bread ○ cakes/pastries ○ flour/meal
○ meat ○ sausage ○ fish ○ shells ○ crawfish/shrimps ○ instant meals
○ tinned food ○ salads ○ onion ○ carrots ○ paprika ○ peas ○ beans
○ lentils ○ potatoes ○ tomatoes ○ strawberries ○ lemons ○ oranges ○ apples
○ pears ○ apricots ○ peaches ○ bananas ○ pineapples ○ cherries ○ spices
○ mayonnaise ○ ketchup ○ beer/wine/sparkling wine ○ red wine ○ tonic water
○ hazelnuts ○ walnut ○ Brazil nuts ○ peanuts ○ almonds ○ others: __________
What happens after eating or drinking of one of the above mentioned foodstuff?

____

Is there a hypersensitivity to some medicine: ○ no ○ yes, to ____________________

Your child has got allergy test (skin prick test) or RAST before?
○ no ○ yes, with Dr.: __________ result: ____________________

Your child has got desensitization therapy ("allergy vaccination") before? ○ no

○ yes, with Dr.: __________ in yr _______ success: __________ ○ side effects: __________

Have you previously tried to strictly avoid the allergen (avoidance therapy)? ○ no ○ yes

Have any operations been performed on your child ○ no ○ yes, namely:
○ (pharyngeal) tonsils ○ adenoids ○ nasal septum ○ paranasal sinus ○ polypus

○ maxillary sinus ○ other: ____________________ ○ date of operation: ____________

Which medications have been used in the past to fight the complaints: ____________________

____ success: __________

Is there any other important information that you would like to add to this questionnaire?

____

____

____