This questionnaire is to be completed, signed and returned to Reception before your appointment can be made.
Most of the questions can be answered by a tick, or only brief answers are required, but feel free to provide as much extra information as you wish.

I have read the information enclosed and understand that the initial consultation may involve skin testing.
Bulk billing does not apply. Payment is to be made at the time of the consultation and a rebate can be later claimed from any Medicare office.

Please note - A cancellation fee of $100 will be charged for patients who do not attend their intial appointment without giving at least 24 hours notice. This fee is not claimable with Medicare.

Name
Address
Signature

Postcode
Date of Birth

Phone
Email

1 At what age did you FIRST have an allergic condition ?

0 - 1 years 1 - 5 yrs 5 - 15 years 15 - 25 yrs 25 + yrs

2 What was your FIRST allergic condition ?

Hay fever Asthma Eczema Skin rash Insect sting

Acute allergic reaction Food allergy

3 Do you still have this first allergic problem ?

Yes No

4 Is your FIRST allergic condition still your main problem ?

Yes No

5 Have any other allergic problems developed since then ?

Asthma Hay fever Eczema Urticaria Skin disorders

Insect sting reactions Food allergies Acute allergic reactions

6 Have you ever had Migraine Sinusitis Bronchitis

Ear infections Bowel disorders

Psoriasis Nose operations

7 Do other family members have allergic conditions ?

Mother Father Sister/s Brother/s

Maternal grandparents Paternal grandparents

8 Have you had previous medical tests or investigations for allergy ?

No (go to Q 13) Yes

9 How many years ago were you tested ?

10 Do you know what tests were done ?

Skin tests Blood tests

11 What did the tests show ?

12 Is it possible to obtain your test results ?

No Yes

13 What medical allergy treatment have you had ?

Add a separate list if necessary

14 Were any of these treatments very helpful ?

No Yes If yes, which

15 Are you exposed to dust, powders or volatile substances in high concentrations at work, gardening, hobbies, etc ? Y N

16 Do you have pets or are you in close contact with any animals ? cat dog horse rabbit
cow sheep bird fish other

17 Are your main symptoms constantly present

mostly present, sometimes not at all

only at certain times of the year

only present at odd times

18 If there is a regular pattern which month do your symptoms begin, and end ? to

19 Which year were your symptoms worst ?

20 Have you been having symptoms during the last 3 months ?

21 Would you describe your problems as

minor moderate severe

22 Do you need to take allergy medications

daily nearly every day once or twice a week

once or twice a month a few times a year

23 When you do have symptoms are they worst

in the morning during the day at night

24 Do you smoke, or do others smoke at home or work

No Yes, I smoke others smoke

25 What sort of heating do you have at home

Ducted gas central heating Electric radiators

Heat banks/ hydronics Open fires

Slow combustion wood heater Other

26 Do you spend much time in air conditioned places ?

at home at work