Allergie-Ambulatorium Innere Stadt

1010 Wien, 1010 Wien, Walfischgasse 3, Tel: 512 79 26, Fax: 512 75 78
www.allergie-wien1.at, office@allergie-wien1.at

Ärztliche Leitung: Prim. Dr. Dorota STEFFANSON

M E D I C A L Q U E S T I O N N A I R E

Dear patient!
Have you been here before? Please let us know at reception.

Please fill out the questionnaire before your appointment. It will help us to evaluate your allergy symptoms quickly.

Data of the patient Date: .....

NAME: .....

Date of birth: ..... Health insurance number: ..... Insurance institution: .....

Phone: ..... E-mail: .....

Address: .....

Current occupation/profession: .....

Place of employment: .....

If the patient is co-insured **- data of the insured person**:

NAME: .....

Date of birth: ..... Health insurance number: ..... Insurance institution: .....

Place of employment: .....

- Have you been previously evaluated for allergies?
  - ❍ No
  - ❍ Yes, **where**: ....., **when**: .....

  The following **allergies** were found**:** .....

- **Reasons for visit:**
  - ❍ coughing
  - ❍ breathing difficulty
  - ❍ running nose
  - ❍ sneezing
  - ❍ stuffy nose
  - ❍ itchy eyes
  - ❍ swollen eyelids
  - ❍ itchy palate
  - ❍ itchy skin
  - ❍ skin rash
  - ❍ digestive problems
  - ❍ others:
  - ❍ .....
  - .....

- **When did symptoms begin?** .....

- **Are your symptoms:** ❍ seasonal* ❍ all year long

  circle **worst months:*

  Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec

- **When/where are your symptoms worst?**
  - ❍ all day long
  - ❍ in the morning
  - ❍ at noon
  - ❍ in the evening
  - ❍ at night
  - ❍ after the meal
  - ❍ at different times:
    ……...
  - ❍ at home
  - ❍ in the open air
  - ❍ at work
  - ❍ during this activity:
    ……..
  - ❍ after consumption of certain food:
    ……...

PLEASE TURN!

- Did you ever have severe symptoms in connection with:
  - ❍ food
  - ❍ medication
  - ❍ insect stings
  - ❍ costume jewellery
  - ❍ vaccinations
  - ❍ others: .....

- Do you, or does anyone living with you, smoke?
  - ❍ No, I don´t.
  - ❍ Yes, at most ..... cigarettes a day.
  - ❍ Yes, I live in a smoking household.

- Do you have any **pets** or contact with **animals**?
  - ❍ No
  - ❍ Yes: ……..……

- What symptoms do you have in contact with a pet?
  - ❍ None
  - ❍ Yes: .....

- Do you have **plants** at your home/work?
  - ❍ No
  - ❍ Yes: ……...

- Is your flat/house infested with **mould**?
  - ❍ No
  - ❍ Yes

- What does your **mattress** consist of: ..... (e.g. latex, horsehair, spring, ..)
- What does you **bedding** consist of: ..……..….... (e.g. wild silk, sheep wool, feathers, ..)

- Do you have any contact with **irritating or toxic substances**?
  - ❍ No
  - ❍ Yes: ……...

- Does anyone in your family suffer from an allergy (parents, siblings, grandparents)?
  - ❍ No
  - ❍ Yes: …….....

- **Do you were diagnosed with hepatitis/HIV**?
  - ❍ No
  - ❍ Yes

- **Do you suffer from any other disease** (e.g. high blood pressure, thyroid disease, glaucoma, …)
  - ❍ No
  - ❍ Yes: …….....

- Please list **all medications**, including allergy and non-allergy medications:
  - ❍ allergy: ……..
  - ❍ non-allergy: ……..

- ***Women***: Are you currently pregnant? ❍ Yes ❍ No
  Do you breastfeed? ❍ Yes ❍ No

- During the **blood test** would you like to:
  - ❍ sit or
  - ❍ lie down

PLEASE NOTE*: The medical report will be sent to your doctor several days after your* ***second*** *visit (discussion of results). Should* ***you*** *require an additional medical report too (for sending by post please deposit 0,85€ for the stamp; download also possible via text message), please let us know at reception.*