

ALLERGY QUESTIONNAIRE
(complete all questions)

Name of primary applicant: _____ ID/SSN: _____

Name of person treated/relationship to applicant: _____

1. Date diagnosed or date of first symptoms: _____

2. Are your allergies seasonal? ___ Yes ___ No. How many episodes per year? _____

3. Have there been any hospitalizations or emergency room visits for this condition?
___ Yes ___ No If yes,

a. Reason for seeking treatment or confinement? _____

b. Date(s) of confinement: _____

c. Number of visits/confinements: _____

d. Name and address of hospital where seen: _____

4. Any work loss or restricted activities? _____

5. Diagnostic studies done:
___ allergy testing ___ x-ray studies ___ specialists exam
___ bronchoscopy ___ pulmonary function

6. Details of treatment:

Medications taken regularly:

Name of Medication:	Dosage:	# Daily
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Medication taken "as needed":

Name of Medication:	Dosage:	Frequency of Use
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Desensitization shots? frequency? _____

7. How often do you see the doctor for this condition? _____

Name and address of treating physician _____

8. What is your current height? _____ and weight? _____

All of the above statements are true, complete and correctly recorded to the best of my knowledge. I understand that the insurer will rely on these statements when determining eligibility.

Signature of person treated (or parent / guardian if under 18)

Date