



21-14 Newtown Avenue
First Floor
Astoria, NY, 11102
Tel: 718.545.0958

ALLERGY QUESTIONNAIRE

Patient's Name: _____

Date: _____

- | | | |
|---|-----|----|
| 1. Does your child have a history of allergies? | YES | NO |
| 2. Does your child have asthma, hay fever, eczema, or rashes? If yes, please circle & comment if necessary. | YES | NO |
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- | | | |
|--|-----|----|
| 3. Is your child allergic to bananas, avocados, chestnuts, nuts, or kiwi fruit? If yes, please circle | YES | NO |
| 4. Is your child allergic to potatoes, milk, peaches, tomatoes, papaya, or passion fruit. If yes, please circle | YES | NO |
| 5. Does your child have food sensitivities | YES | NO |
| 6. Has your child ever experienced itching, hives, swelling or symptoms like a runny nose, wheezing, eye irritation or difficulty breathing after a: | | |
| a. Dental exam or procedure | YES | NO |
| b. Contact with a balloon | YES | NO |
| c. An exam by someone wearing gloves | YES | NO |
| 7. Have you ever been informed by a doctor that your child has a latex or rubber allergy? | YES | NO |

Parent or Guardian Signature: _____

Date: _____

Patient Signature: _____

Date: _____