Questionnaire for Allergic Study
Please answer the questions below to determine your qualification as a control or study subject.

1. A. Have you ever been skin tested for allergies?
   A. If yes, were any of the tests positive?
      Yes       No
   B. If yes, what were you allergic to?

2. Have you ever been diagnosed by a physician as having allergies to pollen, dust, animals or other common allergens?
   Yes       No
   (If No, stop here)

3. TODAY, do you have any of the follow: (circle Yes or No)
   Sneezing     Yes       No
   Hives        Yes       No
   Itchy/Irritated Skin        Yes       No
   Stuffy Nose/Itchy Nose      Yes       No
   Itching or Red eyes         Yes       No
   Coughing      Yes       No
   Wheezing      Yes       No
   Difficulty Breathing       Yes       No

4. Have you experienced any of the above symptoms within the last two days? (Circle Yes or No)
   Yes       No

5. TODAY, are you taking the following medications? (Circle all that apply)
   A. antihistamines
   B. nasal corticosteroids
   C. eye drops
   D. other (please list any other medications that you are currently taking)

6. Is today your second blood draw for this study? (Circle Yes or No)
   Yes       No

If Yes, what was your previous participant number (indicated on the top of your “Instructions for Returning Participants” form)

Approved

Version 8
January 24, 2014

RG/EF 2/20/14
(If No, continue to question 7)

7. Would you be willing to return for a second blood draw when you are no longer symptomatic for at least one month? (Circle Yes or No)
   Yes   No

If, Yes, please remove the next page. This page includes your study participant number and the contact information for the clinic.