Pediatric Allergy New Patient Questionnaire

Patient Name_____ **Today's Date** ____/____/_____

Briefly describe the reason for your child's visit:

_____

_____

Please mark yes or no if you have any concerns about the following allergic issues:

	Yes	No	Age the problem started
Asthma	☐	☐	_____
Seasonal and/or pet allergies	☐	☐	_____
Food Allergy	☐	☐	_____
Eczema/Atopic Dermatitis	☐	☐	_____
Drug Allergy	☐	☐	_____

Past Allergy Testing:

☐ No ☐ Yes Location and Date: _____

Who referred your child to us?

_____

If a doctor/clinic referred your child:

Name

_____

_____

Primary Care Provider (if different from above):

Name

_____

What pharmacy do you use?

_____

Please list any medicines your child takes:

_____

_____

Health Problems (Review of Systems): Circle any of the problems your child has had over the past 2 months:
*****CHECK "None" if your child hasn't had any problems in any section.*****

General
☐ None
Feeling tired all the time Daytime sleepiness Trouble sleeping Fever Chills Weight loss Not gaining weight Overweight Too short Too thin Loss of appetite

Eyes
☐ None
Blurred vision Burning eyes Cataracts Dry Eyes Frequent blinking Watery eyes Itchy eyes Redness Swelling Lazy eye

Ears, Nose, & Throat
☐ None
Snoring Hearing loss Ear pain Nasal polyps Nosebleeds Nasal drainage Itchy nose Sneezing Nasal congestion (stuffy nose) Dry mouth Post-nasal drip Mouth breathing Mouth sores Throat tightness Loss of sense of smell

Heart
☐ None
Chest pain Dizziness Heart Murmurs Fainting spells Irregular heartbeat Fluttering or pounding heartbeat

Lungs
☐ None
Cough Coughing at night Coughing up blood Chest tightness Frequent bronchitis or chest colds Wheezing Low oxygen level Shortness of breath during day, at night or both Trouble breathing when exercising

Gastrointestinal (GI)
☐ None
Chronic belly pain Indigestion Nausea Throwing up Frequent spitting up Heartburn Acid taste in mouth Constipation Diarrhea Bloody poop Burping Gassiness Bloating Slow eater Choking on food Choking while drinking Child complains food gets "stuck" Trouble swallowing Not wanting to eat food with certain textures: _____ Liver problems Jaundice (yellow skin and eyes)

Kidney/Genitourinary
☐ None
Bedwetting Wetting pants Frequent or Painful peeing Kidney problems Urinary stones

Muscles/ Bones
☐ None
Fractures Back pain Joint pain Joint swelling Muscle pain Weakness

Neurological
☐ None
Trouble concentrating Headaches Seizures Numbness Trouble walking Tremors Weakness

Skin
☐ None
Rashes Eczema Skin infections Swelling Hives/welts Itching Hair Loss

Hematology Blood/Lymphoid
☐ None
Low iron Anemia Bruising easily Bleeding easily Blood clots Swollen Lymph Nodes Unexplained lumps

Psychological
☐ None
Nervous Worried Depressed Panic attacks Hyperactive Mood swings Stressed (why?):_____

Medical History

How long was the pregnancy: ☐ Full-term ☐ Early (# of weeks early) _____

Type of delivery: ☐ Vaginal ☐ C-section

Were there any problems with the pregnancy? ☐ No ☐ Yes (specify)_____

Did your child have problems at birth? ☐ No ☐ Yes (specify)_____

Are your child's vaccines up-to-date? ☐ Yes ☐ No (explain):_____

Did your child get the flu shot this year? ☐ Yes ☐ No

Has your child had any of the following illnesses?

	No	Yes	Age of Onset	Number of Times
Ear infections	☐	☐	_____	_____
RSV	☐	☐	_____	_____
Sinus infections	☐	☐	_____	_____
Pneumonia	☐	☐	_____	_____
Croup	☐	☐	_____	_____
Meningitis	☐	☐	_____	_____
Other Illnesses	☐	☐	(specify): _____	

Does your child have any chronic medical condition(s) besides allergies/asthma? ☐ Yes (please list) ☐ No

_____

_____

Has your child ever had to stay overnight in the hospital? ☐ No ☐ Yes

Month/Year Reason:

_____

_____

Has your child ever had surgery? ☐ No ☐ Yes Year

☐ Ear Tube(s) _____

☐ Tonsillectomy _____

☐ Adenoidectomy _____

☐ Sinus Surgery _____

☐ Other:_____ _____

_____ _____

Place Patient Identification Sticker Here

Family Medical History ☐ Adopted ☐ Family history unknown

	Age	Job	Nasal Allergy	Food Allergy	Drug Allergy	Insect Allergy	Asthma	Eczema	Immune Deficiency
Mother									
Father									
Sister									
Sister									
Brother									
Brother									
Other family (grandparents, aunts, uncles, cousins)									

Do any family members have other chronic medical conditions? ☐ No ☐ Yes

(If yes, please list): _____

Social History

Parents marital status ☐ Married ☐ Divorced ☐ Separated ☐ Single

☐ Custody arrangement:_____

Who lives in the home with the child? _____

What grade is your child in? _____

Does your child go to daycare? ☐ No ☐ Yes

Is your child home-schooled? ☐ No ☐ Yes

Are you worried about being able to pay your medical bills? ☐ No ☐ Yes

Place Patient Identification Sticker Here

Home Environment History: Please fill in information about where your child lives

House, apt, condo, mobile home (circle) How long have you lived in your home? _____

Basement?	☐ No	☐ Yes
Carpet?	☐ No	☐ Yes
Heating?	☐ Forced Air	☐ Electric ☐ Gas ☐ Wood Fireplace ☐ Wood-burning stove
Air Conditioning?	☐ No	☐ Yes ☐ Central ☐ Window unit
Swamp Cooler?	☐ No	☐ Yes

Is your child exposed to the following items in their home(s)?

☐ Mold ☐ Water Damage

☐ Other Exposures of Concern:

_____

Pets? (check all that apply)

☐ No ☐ Yes

☐ Dogs #_____	☐ Indoor	☐ Outdoor
☐ Cats #_____	☐ Indoor	☐ Outdoor
☐ Birds #_____	☐ Indoor	☐ Outdoor
☐ Other #_____	☐ Indoor	☐ Outdoor

Type:_____

Do any members of your household use tobacco, marijuana, e-cigarettes, or vape? ☐ No ☐ Yes → ☐ Father ☐ Mother Other(s):_____

Type: _____

Place Patient Identification Sticker Here