PEDIATRIC IMMUNOLOGY NEW PATIENT QUESTIONNAIRE

Patient Name_______________________________________ **Today's Date** ____/____/__________

Date of Birth _____/_____/_______ **Age** _________ **Sex** ☐ Male ☐ Female

Briefly describe the reason for your child's visit:

____

____

Race: ☐ Native American ☐ Asian ☐ African American ☐ Caucasian ☐ Hispanic

☐ Other: _________________

Parents' marital status: ☐ Married ☐ Divorced ☐ Separated ☐ Single

☐ Other (specify): ____

Child lives with: ☐ Both parents ☐ Father ☐ Mother ☐ Other:____

Custody arrangement:____

Who referred your child to us?

____

If a health care provider referred your child:	**Local Pharmacy:**
Name	Name
Address	Address
Phone	Phone
Fax	Fax
Primary Care Physician (if different from above):	**Mail Order Pharmacy:**
Name	Name
Address	Address
Phone	Phone
Fax	Fax

IMMUNOLOGY NEW PATIENT QUESTIONNAIRE
Intake Form

Place Patient Identification Sticker Here

PAST MEDICAL HISTORY

Please list known medical problems for your child:

____

____

Was your child born in the US?	☐ No (specify country)_____________	☐ Yes (specify state) ____________
Length of pregnancy:	☐ Early (# of weeks early) ______ ____	☐ Full-term
Birth weight _____ lbs _____ oz		
Type of delivery:	☐ C-section (planned or emergency?)	☐ Vaginal
Problems with the pregnancy?	☐ Yes (specify)___________________	☐ No
Problems with labor or delivery?	☐ Yes (specify)___________________	☐ No
Newborn breathing problems?	☐ Yes (specify)___________________	☐ No
Was your child breast fed?	☐ Yes (until what age?)____________	☐ No
Was your child formula fed?	☐ Yes (specify formula type)________	☐ No
Your child's growth pattern:	☐ Rapid/Slow (specify)_____________	☐ Normal
Your child's development:	☐ Delayed (specify)_______________	☐ Normal
Your child's puberty (if applicable):	☐ Delayed/Advanced (specify)______	☐ Normal
Are immunizations up-to-date?	☐ No (explain)___________________	☐ Yes

Has your child had any of the following infections?

	No	**Yes**	**Age of Onset**	**Number of Times**
Ear Infections	☐	☐	__________	______________
Sinus Infections	☐	☐	__________	______________
Pneumonia	☐	☐	__________	______________
Blood Infections	☐	☐	__________	______________
Joint/Bone Infections	☐	☐	__________	______________
Tooth Infections or Decay	☐	☐	__________	______________
Gingivitis or Gum Disease	☐	☐	__________	______________
Thrush (after 1 year of age)	☐	☐	__________	______________
Warts	☐	☐	__________	______________
Nail Fungus/Infections	☐	☐	__________	______________
Chicken Pox	☐	☐	__________	______________
Shingles	☐	☐	__________	______________
Molluscum Contagiosum	☐	☐	__________	______________
Herpes or Cold Sores	☐	☐	__________	______________
Mono (EBV)	☐	☐	__________	______________
Other Infections (specify)	☐	☐	__________	______________

Has your child ever had genetic testing? ☐ No ☐ Yes

Specify type, reason, who ordered the testing (and when), and the testing results:

____

Has your child ever been diagnosed with cancer? ☐ No ☐ Yes

Specify type, year of diagnosis, and treatment (chemotherapy, radiation, and/or bone marrow transplant):

____

Has your child ever needed an organ or bone marrow transplant? ☐ No ☐ Yes

Specify type, reason, year of transplant, and history of organ rejection (if any):

____

Hospitalizations? ☐ No ☐ Yes

Month/Year - Reason:

____

____

____

Surgeries/Biopsies? ☐ No ☐ Yes

☐ Ear Tubes (specify year/years)____

☐ Tonsillectomy (specify year/years)____

☐ Adenoidectomy (specify year/years)____

☐ Sinus Surgery (specify year/years)____

☐ Heart Surgery (specify type and year/years):____________________________________

☐ Other Surgeries (specify type and year/years):__________________________________

☐ Biopsies (specify location of body and year/years):______________________________

Scope Procedures? ☐ No ☐ Yes

☐ EGD/Upper Endoscopy (specify year/years)_____________________________________

☐ Colonoscopy/Lower Endoscopy (specify year/years)_______________________________

☐ Bronchoscopy/Lung Scope (specify year/years)__________________________________

☐ Other Endoscopy (specify type and year/years)__________________________________

FAMILY MEDICAL HISTORY

Family Member	Age	Allergies or Asthma	Eczema or Skin Condition(s)	Serious, Unusual, or Frequent Infections	Autoimmune Disease (see list below)	Cancer	GI or Stomach Problems	Other
Father								
Mother								
Sibling 1								
Sibling 2								
Sibling 3								
Others								

Do any family members have autoimmune disease? ☐ No ☐ Yes

☐ Lupus (specify relation)______________________________

☐ Rheumatoid Arthritis (specify relation)______________________________

☐ Hyper- or Hypo-thyroidism (specify relation)______________________________

☐ Type I Diabetes (specify relation)______________________________

☐ Celiac Disease (specify relation)______________________________

☐ Low White Blood Cell, Red Blood Cell, or Platelet Counts (specify type and relation)______________________________

☐ Other Autoimmunity (specify type and relation)______________________________

Do any family members have cystic fibrosis? ☐ No ☐ Yes

If yes, specify relation (brother, cousin, etc.)?______________________________

Do any family members have any other type of lung disease? ☐ No ☐ Yes

If yes, specify relation and type of lung disease______________________________

Do any family members have immune deficiency? ☐ No ☐ Yes

If yes, specify relation______________________________

Have you had unexplained deaths in your immediate or extended family? ☐ No ☐ Yes

If yes, specify relation and age of death______________________________

SOCIAL HISTORY

1. In what grade is your child? _______________
2. Does your child attend daycare? ☐ No ☐ Yes
3. Is your child home-schooled? ☐ No ☐ Yes
4. Do you have difficulty getting your child to take medications? ☐ No ☐ Yes
5. Does your child have problems in school with learning or with teachers? ☐ No ☐ Yes
6. Is your child in special education classes? ☐ No ☐ Yes
7. Has your child been in counseling? ☐ No ☐ Yes

Is your child sexually active (if yes, please specify age of first sexual encounter and number of partners)?
____

Has your child ever used tobacco products, marijuana, or illegal drugs (if yes, please specify when and for how long)?
____

Has your child ever been in a jail or juvenile detention center (if yes, please specify when and for how long)?
____

HOME ENVIRONMENT AND TRAVEL HISTORY

Do you live in a house, apartment, condominium, or mobile home? ____________________________

How old is your place of residence? ____________________________

How long have you lived there? ____________________________

Has your child ever traveled outside the US (if yes, specify where and when)? ____________________________

Pets? (check all that apply)

☐ No ☐ Yes

☐ Dogs #______	☐ Indoor	☐ Outdoor	☐ Indoor/Outdoor	☐ In Bedroom
☐ Cats #______	☐ Indoor	☐ Outdoor	☐ Indoor/Outdoor	☐ In Bedroom
☐ Birds #______	☐ Indoor	☐ Outdoor	☐ Indoor/Outdoor	☐ In Bedroom
☐ Other #______	☐ Indoor	☐ Outdoor	☐ Indoor/Outdoor	☐ In Bedroom

Type:__________________

Are there smokers in the home? ☐ No ☐ Yes → ☐ Father ☐ Mother ☐ Other(s):_____________

HEALTH PROBLEMS (REVIEW OF SYSTEMS): Circle any of the problems your child has had over the past few months

General:	Fatigue Daytime sleepiness Trouble sleeping Fever/Chills Weight loss Poor weight gain Overweight Too short Too thin Loss of appetite	☐ None
Eyes	Blurred vision Burning Cataracts Dry Eyes Frequent blinking Watery eyes Itching Redness Swelling Lazy eye Near-sighted Far-sighted Wears glasses	☐ None
Ears, Nose, & Throat	Snoring Hearing loss Ear pain Nasal polyps Nosebleeds Nasal drainage Itchy nose Sneezing Nasal/sinus congestion Dry mouth Post-nasal drip Mouth breathing Frequent sore throat Mouth sores Throat tightness Loss of sense of smell	☐ None
Heart	Chest pain Dizziness Murmurs Fainting spells Irregular heartbeat Palpitations	☐ None
Lungs	Cough at night Coughing up blood Chest tightness Frequent bronchitis/chest colds Wheezing Low oxygen level Shortness of breath during day OR night Shortness of breath with exercise	☐ None
Gastrointestinal (GI)	Frequent abdominal pain Indigestion Nausea Vomiting Frequent regurgitation/spitting up Heartburn Acid taste in mouth Constipation Diarrhea Bloody stool Encoporesis (soiling pants) Burping Gassiness Bloating Difficulty feeding Choking on food Choking while drinking Trouble swallowing Avoidance of certain textures: ___________ Slow eater Liver problems Jaundice	☐ None
Kidney/ Genitourinary	Bedwetting Wetting pants Frequent or Painful urination Menses: Onset: _____ years Kidney problems Urinary stones	☐ None
Muscles/ Bones	Fractures Back pain Joint pain/swelling Muscle pain or weakness	☐ None
Neurological	Concentration problems Headaches Seizures Numbness Difficulty walking Tremors Weakness	☐ None
Skin	Rashes Eczema Skin infections Swelling Hives/welts Itching Hair Loss	☐ None
Hematology (Blood)/Lymphoid	Anemia Easy bruising Bleeding easily Blood clots Enlarged Lymph Nodes Unexplained lumps	☐ None
Psychological	Anxious/worried Depressed/tearful Panic attacks Hyperactive Mood swings Stressed (why?):______________	☐ None

MEDICATIONS

Has your child ever taken immunosuppressant or biologic drugs? ☐ No ☐ Yes → fill in table below:

Medication Name	Dose	How Often	Taking Now? (If so, for how long)	Taken in Past? (If so, when and for how long)
Prednisone (steroids)				
Abatacept (Orencia)				
Anakinra (Kineret)				
Azathioprine (Imuran)				
Cyclosporine (Gengraf)				
Etanercept (Enbrel)				
Mercaptopurine (Purixan)				
Methotrexate (Otrexup)				
Mycophenolate (CellCept)				
Sirolimus (Rapamune)				
Tacrolimus (Prograf)				
Adalimumab (Humira)				
Eculizumab (Soliris)				
Golimumab (Simponi)				
Infliximab (Remicade)				
Omalizumab (Xolair)				
Mepolizumab (Nucala)				
Rituximab (Rituxan)				
Tocilizumab (Actemra)				
Other (specify:______________)				

Has your child ever been treated with IV or Sub-Q immunoglobulin? ☐ No ☐ Yes → fill in table below:

Medication Name	Dose	How Often	Taking Now? (If so, for how long)	Taken in Past? (If so, when and for how long)
IVIG (IV immunoglobulin)				
SCIG (Sub-Q immunoglobulin)				

Has your child ever been treated with prophylactic/long-term antibiotic, anti-fungal, or anti-viral drugs (taken daily or three times a week for months to years)? ☐ No ☐ Yes → fill in table below:

Medication Name	Dose	How Often	Taking Now? (If so, for how long)	Taken in Past? (If so, when and for how long)
Amoxicillin (Moxatag)				
SMX-TMP (Bactrim/Septra)				
Fluconazole (Diflucan)				
Acyclovir (Zovirax)				
Valacyclovir (Valtrex)				
Other (specify:_____________)				

Does your child take any other medications? ☐ No ☐ Yes → fill in table below:

Medication Name	Dose	Route	How Often	Taken in past month?

<u>FOOD ALLERGY/INTOLERANCE HISTORY</u> – *if your child does not have problems with food, please go to next page.*

<u>Is your child allergic to foods</u>?

☐ No ☐ Yes → Mark all that apply and specify reaction (age, symptoms, last known reaction):

☐ Milk: ______________________________

☐ Egg: ______________________________

☐ Soy: ______________________________

☐ Wheat: ______________________________

☐ Peanuts: ______________________________

☐ Tree nuts: ______________________________

☐ Shellfish: ______________________________

☐ Fish: ______________________________

☐ Other foods:______________________________

Have you been prescribed an epinephrine auto-injector device?	No	Yes
Have you ever had to administer epinephrine to your child?	No	Yes
Do you have emergency medications with you today?	No	Yes
Do you have a Food Allergy Anaphylaxis Action Plan?	No	Yes
Does your child frequently choke or gag while eating?	No	Yes
Does your child complain that food gets stuck while swallowing?	No	Yes
Is your child a slow eater compared to others?	No	Yes
Have you seen a nutritionist before?	No	Yes
Is fear or anxiety concerning food a problem?	No	Yes
Has your child been bullied because of food allergies?	No	Yes

<u>Does your child avoid or refuse particular foods?</u>

☐ No ☐ Yes → Mark all that apply:

☐ Milk

☐ Egg

☐ Soy

☐ Wheat

☐ Peanut / Tree nuts

☐ Shellfish or Fish

☐ Other (specify):______________________________

OTHER ALLERGIC PROBLEMS:

	NO	YES	
Is your child allergic to:			
Animals?	☐	☐	☐ Cats ☐ Dogs ☐Other: __________
Medications?	☐	☐	Specify: ___________________________
Insect stings?	☐	☐	Specify: ___________________________
Latex/rubber?	☐	☐	Specify: ___________________________
Does your child have:			
Nasal allergies?	☐	☐	When? Spring Summer Fall Winter
Eye allergies?	☐	☐	When? Spring Summer Fall Winter
Does your child have:			
Atopic dermatitis (eczema)?	☐	☐	Has your child seen a skin doctor? Yes No
Frequent scratching?	☐	☐	
Frequent hives or swelling?	☐	☐	

If your child has skin problems:

What kind of medicated skin lotions or creams are used? ____

Has your child been prescribed antibiotics for skin infections?_____________________________________

Past Allergy Testing:

☐ No ☐ Yes - Location and Date:____

____ _______________________

Parent/Legally Authorized Representative Signature Date

____ _______________________

Clinician Signature Date

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