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:

<table>
<thead>
<tr>
<th>Allergic Issue</th>
<th>Yes</th>
<th>No</th>
<th>Age the problem started</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asthma</td>
<td>☐</td>
<td>☐</td>
<td>________</td>
</tr>
<tr>
<td>Seasonal and/or pet allergies</td>
<td>☐</td>
<td>☐</td>
<td>________</td>
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<tr>
<td>Food Allergy</td>
<td>☐</td>
<td>☐</td>
<td>________</td>
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<tr>
<td>Eczema/Atopic Dermatitis</td>
<td>☐</td>
<td>☐</td>
<td>________</td>
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<tr>
<td>Drug Allergy</td>
<td>☐</td>
<td>☐</td>
<td>________</td>
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</tbody>
</table>

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**
- 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**
- Blurred vision
- Burning eyes
- Cataracts
- Dry Eyes
- Frequent blinking
- Watery eyes
- Itchy eyes
- Redness
- Swelling
- Lazy eye

**Ears, Nose, & Throat**
- 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**
- Chest pain
- Dizziness
- Heart Murmurs
- Fainting spells
- Irregular heartbeat
- Fluttering or pounding heartbeat

**Lungs**
- 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)**
- 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**
- Bedwetting
- Wetting pants
- Frequent or Painful peeing
- Kidney problems
- Urinary stones

**Muscles/ Bones**
- Fractures
- Back pain
- Joint pain
- Joint swelling
- Muscle pain
- Weakness

**Neurological**
- Trouble concentrating
- Headaches
- Seizures
- Numbness
- Trouble walking
- Tremors
- Weakness

**Skin**
- Rashes
- Eczema
- Skin infections
- Swelling
- Hives/welts
- Itching
- Hair Loss

**Hematology**
- Low iron
- Anemia
- Bruising easily
- Bleeding easily
- Blood clots

**Blood/Lymphoid**
- Swollen Lymph Nodes
- Unexplained lumps

**Psychological**
- 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?

<table>
<thead>
<tr>
<th>Illness</th>
<th>No</th>
<th>Yes</th>
<th>Age of Onset</th>
<th>Number of Times</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ear infections</td>
<td>☐</td>
<td>☐</td>
<td>________</td>
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<td>RSV</td>
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<td>________</td>
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<tr>
<td>Sinus infections</td>
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<td>Pneumonia</td>
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<td>Croup</td>
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<tr>
<td>Meningitis</td>
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<tr>
<td>Other Illnesses</td>
<td>☐</td>
<td>☐</td>
<td>(specify):</td>
<td>__________________</td>
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</tbody>
</table>

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

☐ Ear Tube(s)  Year

☐ Tonsillectomy  ________

☐ Adenoidectomy  ________

☐ Sinus Surgery  ________

☐ Other:____________________ Year

__________________________
**Family Medical History**

<table>
<thead>
<tr>
<th>Age</th>
<th>Job</th>
<th>Nasal Allergy</th>
<th>Food Allergy</th>
<th>Drug Allergy</th>
<th>Insect Allergy</th>
<th>Asthma</th>
<th>Eczema</th>
<th>Immune Deficiency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mother</td>
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<td>Father</td>
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<td>Sister</td>
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<td>Brother</td>
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<td>Brother</td>
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<tr>
<td>Other family (grandparents, aunts, uncles, cousins)</td>
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</table>

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

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:__________________________________________