CHILDREN'S HOSPITAL

ALLERGY/IMMUNOLOGY NEW PATIENT QUESTIONNAIRE

PLACE PATIENT'S LABEL HERE

Date:_____

PART 1: QUESTIONNAIRE

PATIENT NAME:_____D.O.B. _____

Name of Caregiver(s): _____

Relationship to patient _____

Mailing Address: _____

City, State & ZIP: _____

Primary Phone Number: _____-_____-_____ Alternate Phone Number: _____-_____-_____

Email Address: _____

Referred by Physician:_____ Other: _____ Self_____

PHYSICIANS and HEALTH PROFESSIONALS involved; Start with primary care physician

NAME _____ SPECIALTY _____

STREET _____

CITY, STATE & ZIP _____

PHONE_____-_____-_____ FAX_____-_____-_____

NAME _____ SPECIALTY _____

STREET _____

CITY, STATE & ZIP _____

PHONE_____-_____-_____ FAX_____-_____-_____

NAME _____ SPECIALTY _____

STREET _____

CITY, STATE & ZIP _____

PHONE_____-_____-_____ FAX_____-_____-_____

PAGES 1-3 MUST BE COMPLETED IN ORDER TO BEST CARE FOR THE PATIENT. PLEASE ASK FOR ASSISTANCE IF YOU NEED HELP COMPLETING THESE FORMS.

BIRTH HISTORY:

Birth Weight? _____*lbs*_____*oz*
Was the pregnancy normal? ☐ Yes ☐ No
Was the birth a vaginal delivery? ☐ Yes ☐ No
Was special care required after delivery?

IMMUNIZATION HISTORY :

Are the immunizations up to date? ☐ Yes ☐ No ☐ Not sure
Did the patient receive the Measles/Mumps/Rubella vaccine? ☐ Yes ☐ No ☐ Not sure
Did the patient receive the seasonal FLU vaccine this year? ☐ Yes ☐ No ☐ Not sure

PATIENT'S PAST MEDICAL HISTORY:

Nasal allergies?	☐ Yes	☐ No	Heartburn/Reflux?	☐ Yes	☐ No
Asthma?	☐ Yes	☐ No	Autoimmune Disease?	☐ Yes	☐ No
Skin Problems?	☐ Yes	☐ No	Seizures?	☐ Yes	☐ No
Recurrent Ear/Sinus/Lung Infections?	☐ Yes	☐ No	Blood or Immune Disorders?	☐ Yes	☐ No

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List all additional diagnoses.

SURGICAL HISTORY:

Tonsil removal (tonsillectomy)?	☐ Yes	☐ No	Sinus surgery?	☐ Yes	☐ No
Ear tube placement?	☐ Yes	☐ No	Abscess drainage?	☐ Yes	☐ No
Adenoid surgery?	☐ Yes	☐ No	Any other surgery?	☐ Yes	☐ No

List any other surgical procedure(s) and ages of surgeries

SOCIAL HISTORY:

Does the patient live in a house?_____ or Apartment_____ or Mobile Home_____
Is there time split between two different homes? ☐ Yes ☐ No
Does the patient attend daycare or school? ☐ Yes ☐ No

ENVIRONMENTAL HISTORY: Do you or the patient have the following?

Pets? ☐ Cat or ☐ Dog	☐ Yes	☐ No	Central Air/Heat?	☐ Yes	☐ No
Carpeting in the home?	☐ Yes	☐ No	Humidifier?	☐ Yes	☐ No
Visible mold or known water damage?	☐ Yes	☐ No	Use special dust mite mattress covers?	☐ Yes	☐ No
Do any family members smoke?	☐ Yes	☐ No	Use of HEPA air purifiers?	☐ Yes	☐ No

FAMILY HISTORY: Check the box if applicable to the family member.

	Age	Hay Fever	Asthma	Eczema	Food allergy	Drug Allergy	Immune Problems	Other
Mother								
Father								
Sibling(s)								
1.M or F								
2. M or F								
3. M or F								
4. M or F								

IN YOUR OWN WORDS, WHAT IS THE REASON(S) FOR COMING TO OUR CLINIC:

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REVIEW OF SYSTEMS:

Has your child been experiencing any of the following in the last TWO WEEKS?
Mark N/A if you are unable to assess this symptom.

Constitutional	Yes	No	N/A
Feeling tired			
Fevers			
Chills			
Poor weight gain			
Changes in appetite			

Ophthalmologic	Yes	No	N/A
Red or itchy eyes			
Blurred or altered vision			
Sensitivity to light			

Ear/Nose/Throat	Yes	No	N/A
Nasal congestion/discharge			
Snoring			
Nose bleeds			
Loss of smell			

Respiratory	Yes	No	N/A
Cough			
Shortness of breath			
Wheezing			

Cardiac	Yes	No	N/A
Heart racing/palpitations			
Chest pain			

Gastrointestinal	Yes	No	N/A
Diarrhea			
Constipation			
Abdominal pain			
Nausea/Vomiting			
Acid reflux/heartburn			
Blood in stool			

Urinary	Yes	No	N/A
Pain with urination			
Frequent urination			

Hematologic	Yes	No	N/A
Easy bruising or bleeding			
Swollen glands			

Skin	Yes	No	N/A
Rash			
Itching			

Endocrine	Yes	No	N/A
Excessive thirst			
Hot or cold intolerance			
Delayed puberty			

Neurologic	Yes	No	N/A
Headaches			
Dizziness or lightheadedness			
Weakness			
Numbness/tingling			
Seizures			

Psychiatric	Yes	No	N/A
Hyperactivity disorder			
Depression			
Anxiety			
Sleep disturbances			

Musculoskeletal	Yes	No	N/A
Muscle pain			
Joint pain			
Joint swelling			

Any other symptoms we did not mention above? _____

_____

_____

_____

_____

_____

_____

_____

_____

PLEASE ONLY COMPLETE THE SECTIONS BELOW THAT APPLY TO THE PATIENT. IN SOME CASES, YOU WILL NEED TO COMPLETE SEVERAL SECTIONS. CIRCLE THE ANSWER OR CHECK THE BOX AS NEEDED. THANK YOU.

IF THE PATIENT HAS NOSE AND SINUS PROBLEMS:

What symptoms do you/your child have? ☐ Itchy/Runny ☐ Congestion ☐ Both	
Are the symptoms daily? ☐ Yes ☐ No	
Circle the season when they are the worst: ☐ Spring ☐ Summer ☐ Fall ☐ Winter	
What seems to trigger the nasal symptoms? 1._____ 2._____ 3._____	
Does your child frequently have itchy, watery eyes? ☐ Yes ☐ No	
Have you had allergy testing before? ☐ Yes ☐ No	Name of MD:

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IF THE PATIENT HAS ASTHMA OR PERSISTENT COUGHING/WHEEZING:

How Many Days Does He/She Have Symptoms? Circle the answer
☐ Less than 2 Days per Week ☐ 2 or More Days per Week ☐ Every Day

How Often Does He/She Wake Up at Night Due to Asthma/Coughing?
☐ Less than 2 Nights per Month ☐ More than 2 Nights per Month ☐ Every Night

How Often Do You Use a Quick Relief Medicine (Albuterol, Xopenex) To Treat Wheeze or Cough?
☐ Less than 2 Days per Week ☐ More than 2 Days per Week ☐ Every Day

How Many ER or Doctor Visits Did Your Child Make Because of Asthma in the Last 6 Months? _____

# of Times the Patient Received Steroids (oral or steroid shots) in the Last 6 Months? _____

Do You Use Your Quick Relief Medicine Before Exercise to Prevent Coughing or Wheezing? ☐ Yes ☐ No

WHAT ARE YOUR CHILD'S ASTHMA TRIGGERS?
☐ Cold Weather ☐ Allergies ☐ Strong Scents ☐ Exercise ☐ Upper Respiratory Infections ☐ Colds and Flu
Other:_____

IF THE PATIENT HAS ECZEMA OR ITCHY RASHES:

When did he or she develop eczema? ☐ AT BIRTH ☐ 6 MONTHS ☐ Other:_____

Was your child breast fed? ☐ Yes ☐ No

What moisturizer(s) do you use? _____

Has your child had skin infections due to the eczema? ☐ Yes ☐ No

What medicated or prescription creams do you use on his/her skin?

1._____ 2._____ 3._____ 4._____

IF THE PATIENT HAS HAD ANAPHYLAXIS OR A SEVERE ALLERGIC REACTION:

Did the patient have sudden skin rash all over (hives) associated with swelling of any body area, sudden difficulty breathing/coughing, or vomiting/diarrhea?	☐ Yes ☐ No ☐ Not Sure

WHAT CAUSED THE ALLERGIC REACTION? Select below:
☐ Food Ingestion ☐ Medication ☐ Insect Sting ☐ Other:_____ ☐ Unknown

Please Describe Below:

DO YOU HAVE AN EMERGENCY MEDICATION FOR A SEVERE REACTION? ☐ Yes ☐ No	**If yes, select one:** ☐ Epi-Pen ☐ Auvi-Q ☐ Other:_____

IF THE PATIENT HAS FOOD ALLERGIES:
Circle the symptoms that the food causes below:

Food #1:_____
Are you strictly avoiding this food? ☐ Yes ☐ No
☐ Hives ☐ Facial Swelling or Trouble Swallowing ☐ Itchy Skin or Eczema Worsened ☐ Breathing Problems
☐ Vomiting/Diarrhea ☐ Other:_____

Food #2:_____
Are you strictly avoiding this food? ☐ Yes ☐ No
☐ Hives ☐ Facial Swelling or Trouble Swallowing ☐ Itchy Skin or Eczema Worsened ☐ Breathing Problems
☐ Vomiting/Diarrhea ☐ Other:_____

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Food #3:_____

Are you strictly avoiding this food? ☐ Yes ☐ No

☐ Hives ☐ Facial Swelling or Trouble Swallowing ☐ Itchy Skin or Eczema Worsened ☐ Breathing Problems

☐ Vomiting/Diarrhea ☐ Other:_____

DO YOU HAVE AN EMERGENCY MEDICATION FOR A SEVERE REACTION? ☐ Yes ☐ No	**If yes, select one:** ☐ Epi-Pen ☐ Auvi-Q ☐ Other:_____

IF THE PATIENT HAS RECURRENT INFECTIONS OR AN IMMUNE DEFICIENCY:

What type of infections does he/she suffer from? ☐ Ear Infection ☐ Sinus Infection ☐ Pneumonia
How many ear infections in the last 12 months?
How many ear infections in his/her lifetime?
How many times has the patient had pneumonia?

Did the patient receive special vaccines listed below:

Flu vaccine? ☐ Yes ☐ No ☐ Not sure
Pneumonia (Pneumovax) Vaccine? ☐ Yes ☐ No ☐ Not sure

IF THE PATIENT HAS ANY OTHER CONDITION, PLEASE USE THE SPACE BELOW OR INFORM YOUR PHYSICIAN DURING THE VISIT

Thank you for taking the time to complete these forms. It will help us to take the best care possible of you.

Signature of the person filling our these forms X	**Date** MM/DD/YY / /	**Time** 00:00 AM/PM :
Relationship to the patient		

Physician's Signature (indicating completion of History/ROS is neg except as marked) X	**Date** MM/DD/YY / /	**Time** 00:00 AM/PM :