

Please make sure your child does not take any antihistamines for at least three days prior to his/her appointment. If you have any questions about your child's medications, please call the office and we will be happy to help you.

PEDIATRIC

NAME: _____ DATE: _____

What would you like for your child to accomplish during your visit at the Allergy and Asthma Clinic?

- **SYMPTOM HISTORY:** Which of the following symptoms is your child currently experiencing or have experienced in the past?

NASAL/THROAT

- Mucous dripping down the back of your throat (post-nasal drip)
- Congestion or stuffiness
- Sneezing
- Itchy nose/Itchy throat
- Nosebleeds
- Runny nose - what color mucous comes out? _____

SINUSES

- Pain/Pressure
- Congestion
- Headache

EARS

- Itching
- Fullness
- Popping

CHEST

- Cough
- Chest tightness
- Shortness of breath
- Wheezing
- Cough with exercise
- Cough with laughter
- Coughing at night or when you lay down

EYES

- Watering/tearing
- Itching
- Redness
- Swelling

SKIN

- Itching
- Swelling
- Rashes
- Hives/Welts
- Dry skin

HEADACHES

- No
- Yes

Which of the above symptoms bother your child the most?

FOR OFFICE USE ONLY

T: _____ P: _____ RR: _____ BP: _____ NURSE: _____

• **SYMPTOM PROGRESSION:**

- My child's symptoms have been unchanged for some time.
- My child's symptoms have been getting worse over the past few;
 - week
 - months
 - year

My child's symptoms are worse during ;

- spring
- summer
- fall
- winter

- My child's symptoms are present all throughout the year but flare-up during the _____.

• **PROVOKING FACTORS:**

Do any of these things bring on or aggravate your child's symptoms?

- Trees/Pollens
- Dust/Molds
- Dog/Cat/Other animals
- Tobacco smoke
- Weather changes
- Cold air/Air conditioning
- Chemicals/Perfumes
- Exercise or Physical exertion
- Laughter
- Foods: Which ones and what reaction did your child have? _____

EpiPen: Yes No

* My child's diet consists of: _____

• **ALLERGY HISTORY:**

Has your child been treated for allergies in the past?

- No
- Yes

Did he/she see an allergist? NO YES Which doctor? _____

What kind of testing was done? _____ What city? _____

- Skin testing
- Blood testing (RAST)

When was testing done? _____

What were the results? _____

What type of treatment was recommended? _____

If your child was placed on allergy shots, how long was your child on them them? _____

Did allergy shots help with your child's allergies? NO YES

Did your child have any significant reactions to your allergy shots? NO YES,

please explain _____

• **MEDICATION HISTORY:**

Please list **prescription** allergy medications your child is currently taking. Please include all pills, eye drops, nasal sprays and lung sprays.

MEDICATION	DOSE	HOW OFTEN	DOES IT HELP?	SIDE EFFECTS

Please list **over-the-counter** allergy medications (non-prescription) your child is currently taking.

MEDICATION	DOSE	HOW OFTEN	DOES IT HELP?	SIDE EFFECTS

Has your child ever taken any of the following antihistamines?

	YES	NO	DID IT HELP ?	SIDE EFFECTS
1. Allegra 30 mg/60 mg/180 mg	_____	_____	_____	_____
2. Clarinex 5 mg	_____	_____	_____	_____
3. Claritin/loratadine 10 mg	_____	_____	_____	_____
4. Zyrtec 5 mg/10 mg	_____	_____	_____	_____

Please list other medications taken in the past (those not listed above) for your child’s allergy or asthma.

How many times, if any, has your child required treatment with oral steroids such as Prelone? _____

• **GENERAL MEDICAL HISTORY:**

Who is your child’s pediatrician ? _____ City: _____

Please list the names of your child’s other physicians? _____

Is your child allergic to any medications?

No Yes; he/she is allergic to: _____

What type of reaction did your child have? _____

Has your child been hospitalized, if so, for what condition? _____

Has your child had any ER visits, if so, for what condition? _____

REVIEW OF SYSTEMS:

- **CARDIOPULMONARY**
 - Chest pain No Yes
 - Heart Murmur No Yes
 - Palpitations No Yes

- **GENITOURINARY**
 - Burning on urination No Yes
 - Frequency of urination No Yes
- **GASTROINTESTINAL**
 - Heartburn No Yes
 - Abdominal pain No Yes
 - Diarrhea No Yes
 - Vomiting No Yes
- **PSYCHOLOGICAL**
 - Mood changes No Yes
- **SLEEP PATTERN**
 - Snoring No Yes
 - Stop breathing during sleep No Yes
 - Daytime sleepiness No Yes
- **ENDOCRINE**
 - Heat intolerance No Yes
 - Cold intolerance No Yes
 - Excessive thirst No Yes
 - Low/high thyroid No Yes
- **NEUROLOGIC**
 - Weakness No Yes
 - Numbness No Yes
- **MUSCOSKELETAL**
 - TMJ Disorder No Yes

- **IMMUNOLOGIC**
 - Frequent infections No Yes
 - Immune disorder No Yes

- **GENERAL**

Nausea	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Weight gain	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Fever	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Weight loss	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Fatigue	<input type="checkbox"/> No	<input type="checkbox"/> Yes

PAST MEDICAL HISTORY:

Has your child been treated for any of the following conditions? Please check all that apply.

- Asthma
- Gastroesophageal reflux (GERD) Diabetes Liver Disease/Hepatitis RSV
- Eczema Food allergies
- Other _____

What medications is your child currently taking for his/her **other medical conditions**?

MEDICATION	DOSE	HOW OFTEN	FOR WHAT CONDITION

• **SURGICAL HISTORY:**

- None
- Yes, my child has had;
 - Tonsils Date: _____
 - Adenoids Date: _____
 - Ear tube placement
 - Nasal/Sinus surgery Date: _____ Surgeon: _____
 - Other: _____ Date: _____

Were there any complications associated with your child's surgery, including with the anesthesia used?

- No
- Yes; please explain. _____

• **IMAGING STUDIES (XRAYS):**

- None
- Sinuses Date: _____ Results: _____
- Chest Date: _____ Results: _____
- Other _____ Date: _____ Results: _____

• **FAMILY HISTORY:**

Does anyone in your family have any of these conditions?

- Hayfever Who? _____
- Sinus problems Who? _____
- Skin rashes/facial or lip swelling Who? _____
- Asthma Who? _____
- No one in my family has allergies.

MATERNAL HISTORY:

- Living AGE: _____ Any medical problems? No Yes; _____
- Deceased at age: _____ Cause of death: _____

PATERNAL HISTORY:

- Living AGE: _____ Any medical problems? No Yes; _____
- Deceased at age: _____ Cause of death: _____

• **ENVIRONMENTAL HISTORY: HOME**

Do you live in a:

- House
- Apartment
- Townhouse/Condo/Duplex

Does anyone in the house smoke?

- No Yes

Is there smoking in the bedroom?

- No Yes

Do you have any pets?

- No Yes, we have, _____

Are they allowed to come in the bedroom?

- No Yes

Are they bathed?

- No Yes

What type of heating do you have in the house?

- Central furnace with forced-air heating
- Wall heaters
- Radiant-heating system

How old is the system? _____ years old.

- The heating system is new.

Has the system been professionally cleaned?

- Yes, how long ago? _____
- Not since we've lived in the house.
- I don't know.

Are there special allergy filters in the heating system? No Yes

Do you have air-conditioning? No Yes

BEDROOM

Does your child have carpeting in the bedroom? No Yes

There is _____ in the bedroom.

Does your child sleep on any type of feather bedding?

- No
- Yes Pillow Down comforter Feather bed

Does your child sleep on a waterbed? No Yes

Does your child have an air-purifier in the bedroom? No Yes, it runs _____ hours a day.

ADDITIONAL COMMENTS:

Please use this space to expand on any issues you would like us to be aware of:
