Allergy and Immunology Clinic

NEW PATIENT MEDICAL HISTORY QUESTIONNAIRE

Child's Name Last	First	Middle	Date of Birth	Today's Date

Street Address	City	State	Zip	Sex M F	Home Phone ( )

Parents/Legal Guardian:	Cell Phone Father's ( ) Mother's ( )	Best phone number to contact you: ☐Home ☐Mom's cell ☐Dad's cell ☐Other_____

Referring Physician:	Primary care provider:

Current Health Concerns:

What concerns would you like to address today? What are your/your child's main symptoms?

Medical History:

Are you/your child being treated for any health problems or had frequent infections?
☐ Yes ☐ No If yes, please list:

_____
_____
_____
_____
_____
_____
_____
_____

Birth History:
Any complications: ☐No ☐ Yes_____
☐ Vaginal delivery or ☐ C-section
Full term: ☐ Yes ☐ No
If no, how many weeks gestation? _____
Birthweight: _____

Hospitalizations? ☐ Yes ☐ No
If yes, list reason/date(s):

_____
_____
_____
_____
_____
_____
_____

Emergency room visits? ☐ Yes ☐ No
If yes, list reason/date(s):

_____
_____
_____
_____
_____
_____

Surgeries? ☐ Yes ☐ No
If yes, list type of surgery/date(s):

_____
_____
_____
_____
_____
_____

Allergy Testing: Prior allergy testing? ☐Yes ☐No
At what age? _____
What type of testing? ☐Skin prick ☐Blood tests
Which doctor/where?_____
What was the result?_____

_____
_____

Any allergy shot treatments? ☐Yes ☐No
For how long?_____
Did the shots help for allergies? ☐Yes ☐No

Medications: List all prescription, over-the-counter, vitamins, and herbal medications (use back side if needed)

Medication	**Dose** (ex: mg, #puffs)	**Frequency (**as needed?)	**Started when?**

Has your child been prescribed an EpiPen? ☐Yes ☐No

Allergies to Medications: ☐Yes ☐No If yes, list name and type of reaction

_____

Immunizations: Up to date? ☐Yes ☐No

If no, why not? _____

Date of last flu vaccine: _____ Pneumovax vaccine received? ☐No ☐Yes/date_____

Family History: Specify disease as applicable and family member

☐Hay fever/seasonal allergies:	☐Recurrent infections:	☐Gastrointestinal problems:	☐High blood pressure:
☐Asthma:	☐Food allergies:	☐Diabetes:	☐Cancer:
☐Eczema:	☐Lung problems:	☐Heart disease:	☐Congenital/early death:
☐Autoimmune/rheumatologic disease:		☐Other:	

Social/Environmental History:

Who lives with you/your child?_____

_____

_____

School grade/daycare/preschool?_____

Sports/hobbies/occupation/activities:_____

_____

(If we are seeing your child today:)

Mother's occupation:_____

Father's occupation:_____

Type of residence:

☐House ☐Condo ☐Apartment

Location:

☐City ☐Suburb ☐Rural/farm

Circle any that apply:

Bedroom floor: hardwood/ tile/ linoleum/ carpet/ rugs

Pillows & comforter: down or feather / non-feather

Use of: Humidifier / De-humidifier / Room air filter

Dust mite protective covers for bedding? ☐Yes ☐No

Do have a problem with (*check if yes*):

☐ Roaches ☐ Rodents

Does anyone in the household:

☐ Smoke in the home ☐Smoke outside the home

List all family pets:

_____

Diet

During infancy, was your child:

- ☐ Breastfed; until what age?_____
- ☐ Formula fed; what brand/type and when started?_____

~~R~~eview of Systems (check if present):

General: ☐fever ☐chills ☐weight loss ☐weight gain **Skin:** ☐rash ☐eczema ☐hives

Head: ☐headaches ☐lightheadedness ☐hair loss ☐dizziness

Ears: ☐itching ☐fullness/popping ☐hearing problems ☐frequent ear infections

Eyes: ☐itching ☐burning ☐discharge ☐redness ☐ eyelid irritation ☐pain with light ☐changes in vision

Nose/Sinuses: ☐ itching ☐ drainage ☐congestion ☐snoring ☐mouth breathing ☐nasal polyps
☐ sinus infections ☐frequent bloody nose ☐decreased sense of smell

Throat: ☐sore throat ☐post nasal drip ☐throat clearing ☐infection/strep throat ☐thrush

Lungs: ☐dry cough ☐productive/wet cough ☐wheezing ☐chest tightness ☐bloody sputum

Heart: ☐palpitations ☐high blood pressure ☐heart valve problems

Gastrointestinal: ☐nausea/vomiting ☐difficulty swallowing ☐diarrhea ☐abdominal pain ☐heartburn/reflux

Blood/Endocrine: ☐easy bleeding/bruising ☐deep vein thrombosis ☐swollen lymph nodes ☐thyroid problems

Renal: ☐frequent bladder infections ☐blood in urine ☐chronic kidney disease

Musculoskeletal: ☐joint pain ☐joint swelling ☐muscle pain/weakness ☐back pain ☐leg swelling

Neurologic: ☐weakness/clumsiness ☐tingling/burning/numbness ☐delayed development ☐speech delay

Psychologic: ☐anxiety ☐depression ☐difficulty sleeping ☐behavioral issues ☐attention deficit

Other issues?_____

If your child has ECZEMA, please answer the following questions: (otherwise leave blank)

How long has he/she had it?_____
Where is it located? _____
Do you consider it ☐mild; ☐moderate;☐severe
What type of moisturizer(s) are you using? _____
How many times a day do you apply it?_____
Other treatment?: ☐Topical steroids; which one? _____ ☐Antihistamines
How often does your child have a bath? _____
Has your child had any skin infections due to his eczema? ☐yes ☐no; if yes which one _____

If your child suffers from HAYFEVER, please answer the following questions: (otherwise leave blank)

How long has he/she had it?_____
In which season does your child have symptoms? (please list all) ☐Spring, ☐Summer, ☐Fall, ☐ Winter
How many days a week does your child have symptoms? _____
What allergen do you think triggers his/her hayfever? ☐ grass. ☐trees, ☐weeds, ☐dust mites, ☐pets ☐other
Has your child missed school or daycare because of his/her allergies? _____
What type of treatments have you tried? ☐nasal steroids, ☐antihistamines, ☐allergy shots

If your child suffers from ASTHMA, please answer the following questions: (otherwise leave blank)

At what age was your child diagnosed? _____
When do his/her symptoms occur? (please list all) ☐Spring, ☐Summer, ☐Fall, ☐ Winter
How often does your child have symptoms? ☐ less than 2days/week, ☐more than 2 days/week, ☐daily
What medicine is your child on for his/her asthma? ☐inhaled steroids, ☐albuterol ☐other
How many days a week does your child use a rescue inhaler like albuterol? _____
Does your child have symptoms at night that wake him/her up? If yes, how many times a week? _____
What triggers your child's asthma: ☐infections (cold), ☐smoke, ☐allergies, ☐ heartburn, ☐exercise (activity)
Has your child been admitted to hospital due to asthma? ☐yes ☐no; explain? _____
Has your child received oral steroids (prednisone) for his/her asthma? ☐yes ☐no; How many times? _____
Has your child missed school/daycare due to his/her asthma? _____
Does your child use a spacer with his/her inhalers? ☐yes ☐no ☐Not applicable