Alvernon Allergy & Asthma, P.C.

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PEDIATRIC ALLERGY QUESTIONNAIRE

Name: _____ Age: _____ Date: _____
Primary Care Physician: _____ Also notify Dr.:_____
Your relationship to the child_____

1. **Describe what brings your child to Alvernon Allergy and Asthma.**_____
_____
_____

2. **Please circle the allergy related problems.**

NOSE	EYES	EARS	MOUTH/THROAT	CHEST	SKIN
sneezing	itching	itching	sore	cough	itching
itching	burning	fullness	itching	shortness of breath	hives
stuffiness	swelling	popping	swelling	wheezing	rash
mouth breathing	bloodshot	hearing loss	post-nasal drip	sputum	eczema

3. **How long have the symptoms been present**?_____

4. **Symptoms or problems are: ( ) same all year round ( ) worse in the circled months:**
Jul Aug Sept Oct Nov Dec Jan Feb Mar Apr May Jun

5. **Please circle, which make the symptoms worse.**

Stress	Exercise	Infections (colds, etc.)
Heat	Cool temperatures	Weather Changes

6. **Are there any foods avoided or suspected to cause symptoms? (Circle if Yes)**

Eggs	Peanuts	Milk	Nuts	Wheat
Fish	Shellfish	Fruit	Other:_____	

7. **Please list any other exposures that seem to make symptoms worse:**_____
_____

8. **How long has your child lived in Southern Arizona**? _____years/months
Has your child had allergy testing? ( ) Yes ( ) No If Yes, when? _____ Where? _____
Were they skin tests? ( ) Yes ( ) No or other type of tests (explain):_____

9. **Has your child ever had a reaction to an insect sting or bite?** ( ) Yes ( ) No
If Yes, when? _____ Type of reaction: _____
Treatment: _____

10. **Treatment:**
Prescription or "over the counter" medications your child is **presently taking for allergies, asthma, hives or eczema, including those stopped** in preparation of this visit: (inhalers, drops, tablets etc.).

Medication Taken	Is the Medication Effective?	Side Effects
1) _____	_____	_____
2) _____	_____	_____
3) _____	_____	_____
4) _____	_____	_____

Prescription or "over the counter" medications **tried in the past for allergies, asthma, hives or eczema.**
_____
_____

Medications currently taken for **other medical conditions** (include herbal or health store products):

1) _____	3) _____	5) _____
2) _____	4) _____	6) _____

Does your child have issues with taking medications? ( ) Yes ( ) No

Please continue on next page.

Name: _____ DOB: _____

11. Reactions to medications. Please list all medications, prescribed or over the counter, which have caused adverse reactions:

12. Birth History:
Patients gestational age: (circle) full term early(# weeks)____ late(#weeks)____ Weight at birth:_____
How was your child delivered? (circle) vaginal delivery forceps assisted c-section (reason)_____
How was your child fed? (circle) breast fed (length of time)____ formula fed (type)_____
Describe any issues around delivery that may have impacted your child's health:_____
_____

13. Please list any other medical conditions:
1) _____ 2) _____ 3) _____
Hospitalizations or Operations: ( ) No( ) Yes, when and what for: _____
_____
Is your child fully vaccinated? ( ) No ( ) Yes

14. Family History: Is there **allergic rhinitis, asthma or eczema in any family members?**:
Brothers or sisters (list) _____
Parents (list) _____
Are there other medical issues that seem to run in the family?_____

15. Social History:
Daycare: (circle) In-home Large facility Not Applicable
School: Grade_____ Are there any issues in school?_____
Sports and Hobbies:_____
Who lives in your child's home? (list)_____

15. Environment and exposures (please circle):

Type of Home:	House	Apartment		Manufactured Home	
Age of Home:	less than 5 yrs	5 –15 yrs		over 15 yrs old	
Heating system	Gas	Electric		Heat pump	Space heaters
Cooling system:	Evaporative cooler	Air conditioning		Fans only	
Fireplace:	yes but not used		no		
Stove:	Gas	Electric			
Number of inside pets:	Cats_____	Dogs_____	Birds_____	Other_____	
Sleeping place of the pets: _____ Outside pets:_____					
House plants:	less than 20	more than 20			
Are there any smokers in the house?			Yes	No	
If yes, do they smoke in the house or car?			Yes	No	

Is the **bedroom** carpeted?	Yes No				
Type of mattress:	Regular inner spring		Foam	Waterbed	Dust covers?
Type of pillows:	Feather or Down		Foam	Synthetic	Dust covers?
Bedding:	Comforters	Quilts	Wool blankets	Other:_____	
Landscape:	Desert		Non-desert		

17. Review of Systems (Please circle all that apply at the time of this appointment):
General Health: poor growth or weight gain, unexplained fevers, poor sleep, frequent infections
Skin: excessive itch, easy bruising
Ears, nose and throat: ear pain, hearing loss, nose bleeds, sore throat, hoarse voice, snoring
Heart: heart murmur
Lungs: coughing up sputum
Gastrointestinal: complains of stomach ache, vomiting, diarrhea, constipation, vomiting, eating difficulties
Kidney/urinary: pain with urination, blood in urine, frequent urination
Muscles, Bones or Joints: joint pain, joint swelling, broken bones
Nervous System: frequent headaches, seizures, delay in reaching developmental milestones
Mental Health: anxiety, depression, excessive "worry"

Questionnaire incl. ROS reviewed with patient and/or parent:_____

NURSES USE ONLY HT_____ WT_____ BP_____ PULSE_____ RR_____