ALVERNON ALLERGY & ASTHMA, PC

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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 our office:____
____
____

2. Please *circle* the allergy related problems:

NOSE	EYES	EARS	MOUTH/THROAT	CHEST	SKIN
sneeezing	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 circled months:
Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun

5. Please *circle* what makes the symptoms worse:
Stress Exercise Infections (cold, 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 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?________________________________

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)

Medications 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 medication? ( ) Yes ( ) No

Please continue on the other side →

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

12. Birth History:

Patient's gestational age: *(circle)* full term early(#weeks)_____ late(#weeks)_____ birth weight_______

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 (please list)____

Parents (please list)____

Are there any 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? (Please list)____

16. Environment and exposures (*please circle*):

Type of Home:	House	Apartment	Manufactured Home	
Age of Home:	less than 5 years	5 – 15 years	over 15 years 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 so, 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, 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"

Questionaire including Review of Systems reviewed with patient and/or parent (circle) Yes No

NURSES USE ONLY: HT__________ WT___________ BP_____________ PULSE__________ RR___________