

# 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
sneezing	itching	itching	sore	cough	itching
itching	burning	fullness	itching	shortness of breath	hives
stiffness	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"

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

**NURSES USE ONLY:** HT \_\_\_\_\_ WT \_\_\_\_\_ BP \_\_\_\_\_ PULSE \_\_\_\_\_ RR \_\_\_\_\_