Pediatric Allergy and Immunology Patient Questionnaire

This paperwork must be completed and brought with you to your appointment. If it is not completely filled out, your appointment will be rescheduled.

Patient Name________________________________ Appointment Date ______________________________________

Date of Birth ____________________ Age ________________ Sex ____

What is the reason for your child's appointment today? What can we help you with?

____

Primary Care and/or Referring Physician: (this physician will receive a copy of your visit notes)

Name: ____

Address:____

Preferred Pharmacy:

Name: ____

Address: ____

ALLERGIC HISTORY

Allergic nose symptoms? ☐ yes ☐ no If yes, triggers: ☐ animals ☐ indoor dust ☐ outdoor dust ☐ spring ☐ summer ☐ fall ☐ winter ☐ all year long ☐ other__________________

Allergic eye symptoms? ☐ yes ☐ no If yes, triggers: ☐ animals ☐ indoor dust ☐ outdoor dust ☐ spring ☐ summer ☐ fall ☐ winter ☐ all year long ☐ other__________________

Allergic skin symptoms? ☐ yes ☐ no If yes, please describe:____

Allergic reaction to foods (hives, difficulty breathing, swelling, repetitive vomiting, anaphylaxis)? ☐ yes ☐ no

If yes, which food(s) and what was the reaction(s):

____

____

Allergic reactions to medications (hives, difficulty breathing, swelling, repetitive vomiting, anaphylaxis)? ☐ yes ☐no
If yes, which medication(s) and what was the reaction(s):

____

____

Latex allergy? ☐ yes ☐no If yes, describe reaction:____

Allergic reactions to insect stings (hives, difficulty breathing, swelling, repetitive vomiting, anaphylaxis)? ☐ yes ☐no
If yes, which insect and what was the reaction:

____

REVIEW OF SYSTEMS (Please circle any current/recent symptoms)

Constitutional: weight change (intentional/unintentional) appetite change failure to thrive

Skin: rash eczema itching redness swelling hives bruising infections warts
hypo/hyperpigmentation (light or dark spots)

Eyes: watery itchy drainage swelling dark circles creases/lines under eyes contact lenses
change in vision pain sensitivity to light dry eye

Ears/Nose/Throat: hoarseness sore throat poor sense of smell ear pain itchy nose
runny nose nasal congestion polyps nosebleeds postnasal drip sinus congestion
sinus infection (fever, facial pain, >1week symptoms) throat tightness speech difficulties
stridor (noisy inhalation) difficulty inhaling thrush sneezing

Heart: chest pain leg/ankle swelling chest pressure dizziness fainting

Lungs: wheezing (noisy exhalation) chest tightness breathing problems at night (how many nights/month_____)
breathing problems during the day (how many times per week_______________) difficulty exhaling
difficulty with exercise (shortness of breath, wheeze, stridor, cough) cough during the day
cough at night frequent colds frequent bronchitis low oxygen

GI: abdominal pain bloody stools burping choking on food and drink regurgitation/spitting up
gagging with food and drink trouble swallowing heartburn/acid in throat nausea vomiting
constipation diarrhea food texture avoidance (soft/crunchy/bolus)

Musculoskeletal: joint problems (redness, stiffness, pain, large or small joints) fractures

Heme/Lymph: easy bleeding easy bruising poor wound healing large lymph nodes

Sleep: apnea snoring restless sleep daytime fatigue

Psychiatric: anxiety depression/tearful panic hyperactivity developmental delay stress

PREVIOUS ALLERGY/BREATHING TESTING ☐ none ☐ allergy skin testing when?_________________

☐ allergy blood testing when?_________________ ☐ allergy shots when? _________________

☐ Pulmonary function testing when?_________________ ☐ bronchoscopy when?___________________

☐ Chest CT when?_________________ ☐ sinus CT when?_________________

MEDICAL HISTORY

Birth and Developmental History:

Born on Time? ☐ yes ☐ no ☐ unknown If no, how early?____________________

Severe breathing problems at birth? ☐ yes ☐ no ☐ unknown

Cradle cap at birth? ☐ yes ☐ no History of eczema? ☐ yes ☐ no If yes, at what age? ________________________

Birth Weight __________________ Breast fed? ☐ yes ☐ no If yes, for how long? __________________________________

Bottle Fed? ☐ yes ☐ no If yes, dairy based, soy, or elemental formulas?____________________________________

Growth: ☐ normal ☐ rapid ☐ delayed

Development: ☐ normal ☐ delayed

VACCINATION HISTORY

All childhood vaccines received (up to date for age) ☐ yes ☐ unknown ☐ no If no, which required for catch up?

____

Last Flu shot? _________________

DIET HISTORY

☐ unrestricted diet ☐ vegetarian ☐ vegan ☐ gluten-free

☐ avoiding the following foods: ____

Does the patient tolerate bolus foods (meats, breads for example)? ☐ yes ☐ no

Difficulty swallowing or feeling of food or pills getting "stuck"? ☐ yes ☐ no

Diet includes normal portions of (mark all that apply):

☐ milk as such (including dairy such as cheese, yogurt, ice cream) ☐ milk in baked goods

☐ egg as such (whole eggs, mayonnaise, custards, French toast etc) ☐ egg in baked goods

☐ wheat (breads, cereals, crackers etc) ☐ soy (common ingredient in many processed foods) ☐ peanut

☐ other nuts (please circle: pecans, walnuts, almonds, cashews, pistachios, brazil, macadamia, pine, other___________)

☐ seeds (sesame, sunflower, pumpkin) ☐ fish (which fish____)

☐ shellfish (shrimp, crab, lobster, other_____________) ☐ mollusks (clams, scallops, mussels, oysters, other_________)

MEDICAL PROBLEMS

Allergy Related: ☐ Asthma ☐ Allergic eye symptoms ☐ Allergic nasal symptoms

☐ Atopic dermatitis (eczema, dry itchy skin) ☐ Hives ☐ Drug allergy ☐ Insect sting allergy

☐ Food allergy ☐ Heartburn/reflux ☐ Eosinophilic esophagitis ☐ allergic proctocolitis ☐ FPIES

Immunology related ☐ Ear infections (frequent) ☐ Pneumonia ☐ Sinus infections (frequent)

☐ Skin infections ☐ Immunodeficiency ☐ HIV infection

General: ☐ Diabetes ☐ Thyroid disease ☐ Sleep Apnea ☐ Cystic Fibrosis ☐ Other lung disease ☐ autoimmune disease ☐ Kidney disease ☐ Liver disease ☐ Cancer Other:____

HOSPITAL AND SURGICAL HISTORY

<u>Surgeries</u> ☐ none

Tonsillectomy ☐ yes Date____________________ Adenoidectomy ☐ yes Date___________________

Sinus surgery ☐ yes Date(s)____________________ Ear tubes ☐ yes Date(s)____________________

Other Surgeries:

Date______________________ Type ____

Date______________________ Type ____

Date_______________________ Type ____

Date_______________________ Type ____

Date_______________________ Type ____

Hospitalizations ☐none

Date_______________________ Reason ____

Date_______________________ Reason ____

Date_______________________ Reason ____

Date_______________________ Reason ____

Date_______________________ Reason ____

SOCIAL, ENVIRONMENTAL, AND EXPOSURE HISTORY

Race (different races are at risk for different diseases and complications): ☐ Asian ☐Black or African American ☐ Caucasian ☐ Hispanic ☐Jewish (Ashkenazi) ☐ Jewish (Sephardic) ☐Middle Eastern/Arabic ☐Native American ☐ Pacific Islander Other____

Marital Status of Caregivers: ☐ Married ☐Domestic Partners ☐Divorced ☐Separated ☐Single ☐Widowed

Who lives in the home: (parents, caregiver, siblings etc) ____

____

Second hand Nicotine/Tobacco history? ☐ yes ☐no

Type of nicotine: ☐ cigarettes ☐e-cigarettes/vaping ☐ cigars ☐pipe

Other substance exposure (marijuana, methamphetamine, opiates etc)?____________________________________

EDUCATIONAL AND EXPOSURE HISTORY:

Currently in school? ☐ yes ☐no If yes, where?____

Who cares for the child when not in school? ____

Caregiver's Current Occupation(s): ____

Previous occupation(s): ____

Patient's hobbies/activities: ____

Patient lives in: ☐ Apartment/Condo ☐Farm/Ranch ☐Homeless ☐House ☐Mobile home ☐Townhouse

How old is the building: ____________________ How long living there:______________Water Damage? ☐ yes ☐no

Floors (check all that apply): ☐ carpet ☐hardwood ☐tile ☐linoleum ☐laminate ☐concrete

Type of flooring in patient's bedroom? ____________________

Mattress age ______________________________ All furniture bought in Montana?_________________________

Basement? ☐ none ☐finished ☐unfinished ☐damp/musty

Heating system: ____________________________________ Wood fireplace/pellet stove? ☐ yes ☐no

Humidifier? ☐ yes ☐no

Cooling System: ☐ none ☐central air conditioning ☐window air conditioning unit ☐evaporative/swamp cooler

Indoor Pets: ____

Regular exposure to outdoor animals (e.g. horses, farm animals)?____

FAMILY MEDICAL HISTORY

Any of the following diseases in a first degree relative (parent, sibling, child)? If positive, please write which relative.

☐ Asthma/Reactive airways disease ☐Environmental allergies ☐Atopic dermatitis (eczema, dry itchy skin)

☐ Food allergy ☐eosinophilic esophagitis ☐allergic proctocolitis ☐Chronic hives

☐ Bronchitis ☐Chronic cough ☐Croup ☐Pneumonia ☐Sinus infections (frequent)

☐ Ear infections (frequent) ☐Skin infections ☐Immunodeficiency ☐HIV infection ☐ Fevers (frequent)

☐ Heart failure ☐Other heart disease ☐COPD/ Emphysema ☐Sleep Apnea

☐ Cystic Fibrosis ☐Other lung disease ☐autoimmune disease (rheumatoid arthritis, lupus etc)

☐ Kidney disease ☐ Liver disease

Other medical problems in the family not listed above: ____

____

____

MEDICATIONS (please mark current or past, and circle brand if known)

Inhaled as needed bronchodilator: (albuterol, ProAir, Proventil, Ventolin, Maxair, levalbuterol, Xopenex,

other____________) ☐ current ☐past How often needed? _

Inhaled Steroid alone: (Flovent, Pulmicort, QVAR, Alvesco, Azmacort, Aerobid, Asmanex, other__________________)

☐ current ☐ past dose_ _

Combined Inhaled bronchodilator/steroid: (Advair, Symbicort, Dulera, Breo, Air Duo, Wixella, other________________)

☐ current ☐past dose_ _________________________

Inhaled anticholinergic: (ipratropium, Atrovent, Spiriva, Incruse, Tudorza, Seebri other___________________)

☐ current ☐past dose_ _

Other combined inhalers: (Anoro, Bevespi, Trelegy, Stiolto, Breztri, Utibron, DuoNeb, Combivent, other_____________)

☐ current ☐past dose_ _

Oral Steroids: (prednisone, prednisolone, Medrol, decadron, dexamethasone, methylprednisolone, other___________)

☐ current ☐past dose_ _

Topical medications: (hydrocortisone, desonide, triamcinolone, mometasone, fluocinolone, Betamethasone, Eucrisa, Protopic, Elidel, other_____________________)

☐ current ☐past dose_ _

Nasal Steroids: (fluticasone, Flonase, mometasone, Nasonex, triamcinolone, Nasacort, beclomethasone, QNasl,

budesonide, Rhinocort , ciclesonide, Omnaris, Veramyst, xhance other__________________)

☐ current ☐past dose_ _

Oral antihistamines: (diphenhydramine, Benadryl, loratidine, Claritin, Alavert, cetirizine, Zyrtec, fexofenadine, Allegra,

levocetirizine, Xyzal, doxepin, hydroxyzine, Atarax, desloratidine, Clarinex, other_________________________)

☐ current ☐past dose_ _

Nasal Antihistamines: (Astelin, azelastine, Astepro Patanase, olopatadine, other____________________)

☐ current ☐past dose_ _____________

Antihistamine eye drops: (Patanol, Pataday, Bepreve, Zaditor, Alaway, Visene, other_______________)

☐ current ☐past dose_ _

Epinephrine: ☐ current ☐past Brand: EpiPen AuviQ Generic Full dose or Junior?______________________

Other Asthma/Allergy meds: (montelukast, Singulair, Zyflo, zileuton, zafirlukast, Accolate, other_____________)

☐ current ☐past dose_ ________________

Biologic Medications: (Xolair, Dupixent, Nucala, Fasenra, cinquair, Rituximab, IVIG, other________________)

☐ current ☐past dose____

Reflux/Heartburn medications: (Tagamet, cimetadine, Zantac, ranitidine, Pepcid, famotidine, Axid, nizatidine,

Prilosec, omeprazole, pantoprazole, Nexium, other__________) ☐current ☐past Dose_________________________

Antibiotics (current only): Type and dose____

Over the counter pain relievers: (acetaminophen, ibuprofen, Motrin, Tylenol, Naproxen, Aspirin, other_____________)

How often used?____

Homeopathic remedies: ____

____

Vitamins: ____

Supplements: ____

____

Any other medications:

Name: _____________________________ Dose: ____

Name: _____________________________ Dose: ____

Name: _____________________________ Dose: ____

Parent/Guardian Signature ____ Date ____________________

Physician Signature ____ Date _____________________