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 <u>circle</u> 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 <u>circle</u>, 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? (<u>Circle</u> 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 **<u>presently taking</u> <u>for allergies, asthma, hives or eczema</u>, 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 **<u>tried in the past for allergies, asthma, hives or eczema.</u>**
____
____

Medications currently taken for **<u>other medical conditions</u>** (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, <u>prescribed or over the counter</u>, 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 **<u>allergic rhinitis, asthma or eczema in any family members?</u>**:

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 <u>circle</u>):

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 **<u>bedroom</u>** 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”

<u>Questionnaire incl. ROS reviewed with patient and/or parent:_________</u>

NURSES USE ONLY HT________ WT________ BP_________ PULSE________ RR________