Pediatric Allergy New Patient Forms
Date: _____

Name: _____ DOB: _____

Briefly describe the reason for your child's visit: _____
_____

Who referred your child to us? _____

Birth and General History
How long was the pregnancy: ☐ Full-term ☐ Early (# of weeks early) _____
Type of delivery: ☐ Vaginal ☐ C-section
Were there any problems with the pregnancy? ☐ No ☐ Yes (specify)_____
Did your child have problems at birth? ☐ No ☐ Yes (specify)_____
Are your child's vaccines up-to-date? ☐ Yes ☐ No (explain):_____
Did your child get the flu shot this year? ☐ Yes ☐ No
Does your child have any chronic medical condition(s) besides allergies/asthma? ☐ Yes ☐ No
If yes, please list: _____
_____

Please only fill out relevant history below

Asthma History
Does your child have asthma? ☐ No ☐ Yes
If yes-
Do you feel that your child is doing well currently? ☐ No ☐ Yes
Age of Diagnosis: _____
Has your child ever been hospitalized? ☐ No ☐ Yes
If yes, please provide dates: _____
Has your child ever been admitted to the ICU due to asthma ☐ No ☐ Yes
If yes, please provide dates: _____

In the past year:
Has your child been in the ER or Urgent Care due to asthma? ☐ No ☐ Yes
If yes, please provide dates: _____
Has your child been hospitalized due to asthma? ☐ No ☐ Yes
If yes, please provide dates: _____
Has your child been given oral steroids? ☐ No ☐ Yes
If yes, please provide dates: _____
Has your child missed school due to asthma? ☐ No ☐ Yes
How many times has your child seen their primary care doctor due to asthma? _____

In the past 30 days:
How many days has your child had cough, wheeze, or difficulty breathing? _____

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How many nights has your child woken during sleep because of cough, wheeze, or difficulty breathing? _____
How many days has your child had to use Albuterol (emergency inhaler)? _____
Has your child had difficulty exercising? _____

What triggers your child's asthma? _____
Asthma Medications: _____
_____
Does your child use a spacer and mask? ☐ No ☐ Yes

Environmental Allergy History
Does your child have runny nose or congestion? ☐ No ☐ Yes
Does your child have sneezing? ☐ No ☐ Yes
Does your child have itchy or red eyes? ☐ No ☐ Yes
Is your child currently using medications for allergies? ☐ No ☐ Yes
If yes, please specify: _____

Food Allergy History
Does your child have food allergies? ☐ No ☐ Yes
If yes, please specify:

1) Food: _____
   Reaction: _____
2) Food: _____
   Reaction: _____
3) Food: _____
   Reaction: _____

Has your child ever been prescribed an Epipen? ☐ No ☐ Yes

Medication Allergy
Does your child have medication allergies? ☐ No ☐ Yes
If yes, please specify:

1) Medication: _____
   Reaction: _____
2) Medication: _____
   Reaction: _____

Venom Allergy
Has your child ever had a reaction to insect stings? ☐ No ☐ Yes
If yes, please specify:

1) Insect: _____
   Reaction: _____

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Eczema History

Does your child have a diagnosis of eczema or dry, itchy skin? ☐ No ☐ Yes
If yes-
Are the symptoms well controlled? ☐ No ☐ Yes
What locations on the body are affected? _____
What over the counter creams/lotions are you using (if any)? _____
What prescription creams/lotions are you using (if any)? _____
What detergent do you use for your laundry? _____
Do you use fabric softener and/or dryer sheets? _____
How often does your child bathe/shower? _____

Hives History

Does your child have hives unrelated to foods? ☐ No ☐ Yes
If yes, what medications have you used? _____

Infection History

Has your child had any of the following illnesses? ☐ No ☐ Yes
If yes, please check off and list number of times:
☐ Ear infection _____
☐ Sinus infection _____
☐ Pneumonia _____
☐ Skin infection _____
☐ Abscess (boils) _____
☐ Fungal infection _____

Has your child ever been hospitalized for infection? ☐ No ☐ Yes
If so, which infection and when:
_____
How many times has your child received antibiotics? _____

Has your child ever had surgery? ☐ No ☐ Yes (please list with year)
☐ Ear Tube(s) _____
☐ Tonsillectomy _____
☐ Adenoidectomy _____
☐ Sinus Surgery _____
☐ Other: _____

Social/ Home Environment History

Does your child live in a house or an apartment? _____
Who lives in the home with the child? _____

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Does the child live in more than one home or spend a lot of time in other homes? _____
Do any members of your household use tobacco, marijuana, e-cigarettes, or vape? ☐ No ☐ Yes
If yes, inside or outside of the home? _____
Does your child go to daycare? ☐ No ☐ Yes

Within ANY of the homes, are there:
Carpets/Rugs? ☐ No ☐ Yes
Curtains? ☐ No ☐ Yes
Stuffed Animals? ☐ No ☐ Yes
Humidifier? ☐ No ☐ Yes
Air Purifier? ☐ No ☐ Yes
Vacuum? ☐ No ☐ Yes
Mold? ☐ No ☐ Yes
Mice? ☐ No ☐ Yes
Roaches? ☐ No ☐ Yes
Pets? ☐ No ☐ Yes ☐
Dogs #_____ ☐ Cats #_____ ☐ Other #_____ Type:_____

Family Medical History ☐ Adopted ☐ Family history unknown

	Age	Job	Nasal Allergy	Food Allergy	Drug Allergy	Insect Allergy	Asthma	Eczema	Immune Deficiency
Mother									
Father									
Sister									
Sister									
Brother									
Brother									
Other family (grandparents, aunts, uncles, cousins)									

Do any family members have other chronic medical conditions? ☐ No ☐ Yes

(If yes, please list): _____

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Problems (Review of Systems): Circle any problems your child has had in the past 2 months:

General
☐ None
Feeling tired all the time Daytime sleepiness Trouble sleeping
Fever Chills Weight loss Not gaining weight Overweight

Eyes
☐ None
Blurred vision Burning eyes Dry Eyes Watery eyes
Cataracts Itchy eyes Redness Swelling

Ears, Nose, & Throat
☐ None
Snoring Hearing loss Ear pain Nasal polyps Nosebleeds
Nasal drainage Itchy nose Nasal congestion (stuffy nose)
Sneezing Dry mouth Post-nasal drip Mouth breathing
Mouth sores Throat tightness Loss of sense of smell

Heart
☐ None
Chest pain Dizziness Heart Murmurs Fainting spells
Irregular heartbeat Fluttering or pounding heartbeat

Lungs
☐ None
Cough Coughing at night Coughing up blood Chest tightness
Wheezing Shortness of breath during day, at night or both
Trouble breathing when exercising

Gastrointestinal
☐ None
Chronic belly pain Indigestion Nausea Throwing up
Frequent spitting up Heartburn Constipation Diarrhea
Bloody poop Burping Gassiness Bloating Choking on food
Choking while drinking Slow eater Trouble swallowing
Complains food gets "stuck" Not wanting to eat certain textures
Liver problems Jaundice (yellow skin and eyes)

Kidney/Urinary
☐ None
Bedwetting Frequent or Painful peeing

Muscles/ Bones
☐ None
Joint pain Joint swelling Muscle pain Muscle Weakness

Skin/Hair
☐ None
Dry Skin Swelling Hives/welts. Itching Hair Loss

Blood/Lymphoid
☐ None
Bruising or bleeding easily Blood clots Swollen Lymph Nodes

Neurological
☐ None
Headaches Seizures Numbness. Trouble walking Tremors

Psychological
☐ None
Worried Depressed Hyperactive Mood swings

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