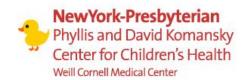


# PEDIATRIC ALLERGY QUESTIONNAIRE

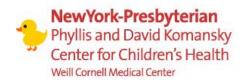
Today's	Date:		
Patient	's Name:	Date of Birth:	Age:
Addres	s:		Phone:
Referre	ed To This Office By:		
Primary	y Care Physician/Pediat	rician:	Phone:
Addres	s:		Fax:
1.	CHIEF COMPLAINT (re	eason for visit):	
1.	CHIEF COMPLAINT (IT	ason for visity.	
2.	PRIOR ALLERGY EVAL	UATION AND TREATMENT:	
	Has your child been pr	reviously evaluated for allergies? Yes	No 🗌
	(If yes, complete this	s section)	
	Has your child ever ha	d an allergy skin test? Yes 🔲 No 🗌	
	If yes, Date:	Results:	
	Has your child ever ha	d an allergy blood test? Yes 🔲 No 🗌	
	If yes, Date:	Results:	
	Has your child ever re	ceived immunotherapy (allergy shots)? Ye	es No No
	If yes, Dates:	For what allergies?	





3.	3. FOOD REACTIONS: Yes No (If yes, complete this section)								
	A. How lon	g was your child breastfed?	Exclusively? Y	Exclusively? Yes No					
	B. Reaction	s/symptoms during breastfeed	ing? Materr	? Maternal dietary restrictions?					
	C. When w	as formula first introduced?	Which formula?	Reactions?					
	D. Has your	child been on any special diets	? Avoiding any food	ls?					
	If ye	<b>s</b> , please list in the table below:							
				0.111.2					
	<u>Food</u>	Age Avoided	<u>Symptoms</u>	Still Avoiding?					
	bananas nuts? Y	, melons, apples, peaches, pear es	s, kiwi, citrus, tomato, potat	w/fresh fruits or vegetables (i.e.					
	If yes, please list specific food triggers and age of onset:								





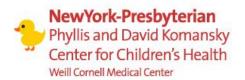
4.	ASTHMA HISTORY: Yes	☐ No ☐	(If yes, complete	te this se	ction)			
	Age of onset:	Frequency o	f attacks:	Most	t recent exacerbation:			
	Has your child had brond	chiolitis (i.e. R	SV) in the past?	Yes 🗌	No 🗌			
Has your child ever needed any of the following for asthma? (Please answer with the most first.)								
	Hospital admissions:							
	Emergency room visits:							
	ICU admissions:							
	Intubations:							
Symptoms: Wheeze Cough Sputum Exercise Intolerance Chest Pain Shortness of breath								
	Night time cough: Yes [	□ No □						
	Season worse in: Winte	er Spring	Summer [	Fall				
	Triggers:							
5.	ALLERGY & ASTHMA TR	IGGERS: (Plea	se select choice	s, check	"Yes" or "No", and list symptoms)			
			Yes	<u>No</u>	<u>Symptoms</u>			
	Grass exposure							
	Tree exposure							
	Raking leaves Mow	ving lawn						
	Damp areas with mold a	nd mildew						
	Sweeping Dusting	Vacuumi	ng 🗌 💮					
	Smog Air Pollution							
	Temperature changes (h	ot cold						





			<u>Yes</u>	<u>No</u>	<u>Symptoms</u>
	Tobacco smoke				
	Exercise				
	Animals (cats, dogs, etc)				
	Coughing after drinking cold or he	ot water			
	Colds (Virals URI's)				
	Cleaning agents, fumes, perfume	S			
	Others:				
6.	INSECT ALLERGY: Yes \( \square\) No \( \square\)	(If yes, comp	lete this	section)	
	Insect: Unknown Honeybee	e 🗌 Yellow jac	ket 🗌	Wasp [	☐ Hornet ☐ Fire ant ☐
	Symptoms:				
	Local swelling	Generalized	d swelling	3	Hives
	Pain	Wheezing			Shortness of breath
	☐ Throat tightening	☐ Difficulty sv	vallowin	g	Loss of consciousness
7.	LATEX ALLERGY: Yes No	(If yes, compl	lete this	section)	

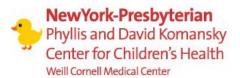




#### 8. MEDICATIONS

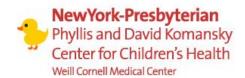
		Please list <b>ALL medications</b> , including any <b>herbal or alternative medications</b> , that your child is <b>currently taking (including dosage and frequency)</b> :							
	Has	Has your child ever been on the following medications:							
Nasal Sprays: Rhinocort Flonase Nasonex Astelin Other:									
	If yes, when, and at what dose & frequency?								
		Inhalers: Proventi Advair	I/Albuterol [ Inhaled cro	Xopenex Domolyn Dtl	Flovent Pulmicort her:	Qvar			
		If yes, when, a	nd at what dose	e & frequency?	Last time used:				
9.	ME	DICATION/DRUG REACTION	NS: Yes 🗌 No	o 🗌 (If yes, con	mplete this section)				
	Dat	te Drug		Reaction	Taken	Since			
10.	PRI	ENATAL AND BIRTH HISTOR	<b>Y</b> :						
		Length of pregnancy (gesta		eeks Anvinrohl	ems during the pregnanc	v?			
	,	Were there any problems v		_		<b>,</b> .			
		If yes, please describe							
	В.	Is your child the product of	<sup>-</sup> Caesarian Sect	ion? Yes 🔲 No	o 🗌				
	C.	Infant's birth weight:	pounds	ounces	Infant's birth length:	inches			





11.	11. HISTORY OF REPEATED INFECTIONS: Yes No (If yes, complete this section)							
	Тур	<u>oe</u>	<u>Date</u>	Antibiotic needed	Abnormal tests (i.e. Chest X-rays/ CT Scans/Blood tests)			
	Ear	Infections						
	Sin	usitis						
	Pne	eumonia						
	Bro	onchitis						
	Me	ningitis						
	Der	ntal Infections						
	Bla	dder/Kidney Infections						
	Skir	n Infections						
	Joir	nt Infections						
	Gas	strointestinal Infections						
12.	ОТІ	HER MEDICAL/SURGICAL HIS	TORY: (Please	e answer all items)				
	A.	List other medical illnesses:						
	В.	Any surgeries:						
	C.	Any ER visits/hospitalization	s? For respirat	tory or allergic reactions	? When?			
		What treatment did he/	she receive?					
	D.	For girls, are her menstrual p	periods regula	r? Yes 🗌 No 🗌				
		Number of days of typic	al cycle:					

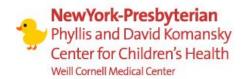




## **13. IMMUNIZATIONS**:

A.	A. Are your child's immunizations up to date? Yes \(\bigcap\) No \(\bigcap\) If <b>no</b> , explain why:							
В.	3. Which immunizations listed below has your child received?							
	<ul><li>Diphtheria</li><li>Tetanus</li><li>Measles</li><li>Mumps</li></ul>	Po	ubella olio IB epatitis	Prevnar Pneumovax Meningococcal Varicella				
C.	C. Please list any adverse reactions to any immunizations:							
D.	D. Did your child receive the influenza (flu) shot during the most recent or current flu season?  Yes No							
E.	Do you plan for your child to obtain	the flu	shot fo	r the upcoming season? Yes No				
	AMILY HISTORY: (please complete)							
M	lother's health: age:			r's health: age:				
Bro	other(s)' health: age:		Sister	(s)' health: age:				
Do	o any family members have a history c	of the fo	llowing					
<u>III</u>	ness	f the fo	ollowing <u>No</u>	g? (If yes, please chack all that apply)  List Relatives (indicate if outgrown and when)				
<u>III</u>		1						
III As	ness	1						
III As	ness sthma	1						
As Fr	ness sthma requent Bronchitis	1						
As Fr Fr Cy	ness sthma requent Bronchitis requent Pneumonia	1						
As Fr Cy	ness sthma requent Bronchitis requent Pneumonia systic fibrosis or Other Lung Disease	1						
As Fr Fr Cy Ha	ness sthma requent Bronchitis requent Pneumonia systic fibrosis or Other Lung Disease ay fever/ Allergic rhinitis	1						
Err Cy Ha	ness sthma requent Bronchitis requent Pneumonia ystic fibrosis or Other Lung Disease ay fever/ Allergic rhinitis nronic Sinus problems	1						
Ecc	ness sthma requent Bronchitis requent Pneumonia rystic fibrosis or Other Lung Disease ray fever/ Allergic rhinitis ronic Sinus problems rives/ Urticaria	1						
As Fr Cy Ha	ness sthma requent Bronchitis requent Pneumonia systic fibrosis or Other Lung Disease ay fever/ Allergic rhinitis nronic Sinus problems sives/ Urticaria	1						
EC	ness sthma requent Bronchitis requent Pneumonia restic fibrosis or Other Lung Disease ray fever/ Allergic rhinitis ronic Sinus problems rives/ Urticaria rezema ligraines	1						
Eco	ness sthma requent Bronchitis requent Pneumonia systic fibrosis or Other Lung Disease ay fever/ Allergic rhinitis nronic Sinus problems rives/ Urticaria szema ligraines sect Allergy	1						
As Fr Cy Ha Cr Hi Ecc M In Di Fc	ness sthma requent Bronchitis requent Pneumonia rystic fibrosis or Other Lung Disease ray fever/ Allergic rhinitis ronic Sinus problems rives/ Urticaria rezema ligraines sect Allergy rug Allergy	1						
Eco	ness sthma requent Bronchitis requent Pneumonia systic fibrosis or Other Lung Disease ay fever/ Allergic rhinitis nronic Sinus problems rives/ Urticaria szema ligraines sect Allergy rug Allergy pod Allergy	1						
Economic Cee	ness sthma requent Bronchitis requent Pneumonia restic fibrosis or Other Lung Disease ray fever/ Allergic rhinitis ronic Sinus problems restives/ Urticaria rezema ligraines sect Allergy rug Allergy rug Allergy rug Disease	1						

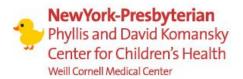




<u>Illness</u>		Yes	<u>No</u>	List Relatives (indicate if outgrown and when)
Inflammatory bow	el disease			
Early unexplained of	death in infancy			
Frequent miscarria	ges			
- FAIVUDONINAENITAL	CLIDVEV.			
5. ENVIRONMENTAL	SURVEY:			
5. ENVIRONMENTAL List the cities and s		child has liv	ved fro	m birth to present:

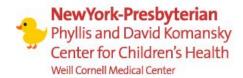
	City State Years Effects on Symptoms (better, worse, no change)
<ol> <li>1.</li> <li>2.</li> <li>3.</li> <li>4.</li> </ol>	
A.	Approximately how old is your home? How long have you lived there?
B.	Is your home a(n): single family home brownstone/townhouse apartment
C.	Does your home have:  Central AC Window AC Mall Unit AC HVAC (heat & AC) wall unit Forced heat Radiator heat Gas heat Electric heat Humidifier Damp areas HEPA filter
D.	Do your windows have:
E.	Does your <b>child's bedroom</b> have:  wall-to-wall carpeting  hardwood flooring  area rugs
F.	Where is your child's bedroom located? (floor or level of house)
G.	On your child's bed, are there:  Stuffed toys Dust mite proof covers Feather pillows Weekly washing of bed linens
Н.	Do you have any pets (cats, dogs, birds, gerbils, hamsters, etc)?
l.	If you have pets, do they enter your child's Dedroom and/or bed.
J.	Are there any pet animals at school or work? Yes  No
K.	Have you seen any pests in your home? Yes No Other:
L.	Are there any smokers in the home? Yes  No
M.	Father's Occupation: Mother's Occupation:
N.	Other environmental exposures? Yes  No  Where?





O. Are your child's symptoms worse at school/work than at home?						





#### **Race and Ethnicity Information**

We want to make sure that all our patients get the best care possible. We would like you to tell us your child's racial and ethnic background as well as your preferred language so that we can review the treatment that all patients receive and make sure that everyone gets the highest quality of care. You may decline to answer if you wish.

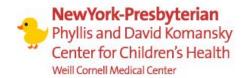
The only people who see this information are registration staff, administrators for the practice, your care providers, and the people involved in quality improvement and oversight, and the confidentiality of what you say is protected by law.

Please mark the appropriate response:

<u>Primar</u>	y Language			
Alb	anian	American Sign Language	Arabic	Armenian
Ber	ngali	Bosnian	Cantonese (Chinese	e)
Cre	ole	Croatian	☐ ECH	Danish
Eng	glish	French	German	Greek
Hel	brew	Hindi	Indonesian	Italian
ПЈар	anese	Korean	Latin	Malay
Ma	ndarin (Chinese)		Persian	Polish
Por	tuguese	Romanian	Russia	Serbian
Slo	vak	Spanish	Swahili	Swedish
Tag	galog	Thai	Turkish	Urdu
U Vie	tnamese	Yiddish	Yugoslavian	Other
Dec	clined	Unknown		
Bla	erican Indian or A ck or African Ame nite clined		Asian Native Hawaiian or Other P Other Combination Not De	
No	panic or Latino or	Spanish Origin o or Spanish Origin		



Fax Number:



## **Pharmacy Information**

So that you and your physician may take advantage of e-prescribing, we need you to provide information on the pharmacy that you choose to use to fill you or your child's prescriptions. Electronic prescription requests are more efficient, accurate and cost effective. Feel free to speak with your physician if you have additional questions. New Date: Patient Name: NYH #: **PRIMARY** Pharmacy Name: Address: Phone Number: Fax Number: **SECONDARY** (if applicable) Pharmacy Name: Address: Phone Number: