Weill Cornell Medicine
Pediatric Allergy & Immunology

NewYork-Presbyterian
Phyllis and David Komansky
Center for Children's Health
Weill Cornell Medical Center

PEDIATRIC ALLERGY QUESTIONNAIRE

Today's Date:

Patient's Name: Date of Birth: Age:

Address: Phone:

Referred To This Office By:

Primary Care Physician/Pediatrician: Phone:

Address: Fax:

1. **CHIEF COMPLAINT (reason for visit):**

2. **PRIOR ALLERGY EVALUATION AND TREATMENT:**

Has your child been previously evaluated for allergies? Yes ☐ No ☐

(***If yes, complete this section)***

Has your child ever had an allergy skin test? Yes ☐ No ☐

If yes, Date: Results:

Has your child ever had an allergy blood test? Yes ☐ No ☐

If yes, Date: Results:

Has your child ever received immunotherapy (allergy shots)? Yes ☐ No ☐

If yes, Dates: For what allergies?

3. FOOD REACTIONS: Yes ☐ No ☐ (***If yes, complete this section)***

A. How long was your child breastfed? Exclusively? Yes ☐ No ☐

B. Reactions/symptoms during breastfeeding? Maternal dietary restrictions?

C. When was formula first introduced? Which formula? Reactions?

D. Has your child been on any special diets? Avoiding any foods?

If yes, please list in the table below:

Food	**Age Avoided**	**Symptoms**	**Still Avoiding?**

E. Does your child complain of itching in his/her mouth after eating raw/fresh fruits or vegetables (i.e. bananas, melons, apples, peaches, pears, kiwi, citrus, tomato, potato), shellfish, peanut, or tree nuts? Yes ☐ No ☐

If yes, please list specific food triggers and age of onset:

4. ASTHMA HISTORY: Yes ☐ No ☐ (***If yes, complete this section)***

Age of onset: Frequency of attacks: Most recent exacerbation:

Has your child had bronchiolitis (i.e. RSV) in the past? Yes ☐ No ☐

Has your child ever needed any of the following for asthma? (Please answer with the most recent 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: Winter ☐ Spring ☐ Summer ☐ Fall ☐

Triggers:

5. ALLERGY & ASTHMA TRIGGERS: (Please select choices, check "Yes" or "No", and list symptoms)

	Yes	No	Symptoms
Grass exposure	☐	☐	
Tree exposure	☐	☐	
Raking leaves ☐ Mowing lawn ☐	☐	☐	
Damp areas with mold and mildew	☐	☐	
Sweeping ☐ Dusting ☐ Vacuuming ☐	☐	☐	
Smog ☐ Air Pollution ☐	☐	☐	
Temperature changes (hot ☐ cold ☐)	☐	☐	

	Yes	No	Symptoms
Tobacco smoke	☐	☐	
Exercise	☐	☐	
Animals (cats, dogs, etc…)	☐	☐	
Coughing after drinking cold or hot water	☐	☐	
Colds (Virals URI's)	☐	☐	
Cleaning agents, fumes, perfumes	☐	☐	
Others:	☐	☐	

6. **INSECT ALLERGY: Yes** ☐ **No** ☐ ***(If yes, complete this section)***

Insect: Unknown ☐ Honeybee ☐ Yellow jacket ☐ Wasp ☐ Hornet ☐ Fire ant ☐

Symptoms:

☐ Local swelling	☐ Generalized swelling	☐ Hives
☐ Pain	☐ Wheezing	☐ Shortness of breath
☐ Throat tightening	☐ Difficulty swallowing	☐ Loss of consciousness

7. **LATEX ALLERGY: Yes** ☐ **No** ☐ ***(If yes, complete this section)***

Date	Source	Reaction

8. MEDICATIONS

Please list **ALL medications,** including any **herbal or alternative medications,** that your child is **currently taking (including dosage and frequency):**

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: ☐ Proventil/Albuterol ☐ Xopenex ☐ Flovent ☐ Pulmicort ☐ Qvar
☐ Advair ☐ Inhaled cromolyn ☐ Other:

If yes, when, and at what dose & frequency? Last time used:

9. MEDICATION/DRUG REACTIONS: Yes ☐ No ☐ ***(If yes, complete this section)***

Date	**Drug**	**Reaction**	**Taken Since**

10. PRENATAL AND BIRTH HISTORY:

A. Length of pregnancy (gestation): weeks. Any problems during the pregnancy?

Were there any problems with the delivery? Yes ☐ No ☐

If yes, please describe:

B. Is your child the product of Caesarian Section? Yes ☐ No ☐

C. Infant's birth weight: pounds ounces Infant's birth length: inches

11. HISTORY OF REPEATED INFECTIONS: Yes ☐ No ☐ ***(If yes, complete this section)***

Type	**Date**	**Antibiotic needed**	**Abnormal tests (i.e. Chest X-rays/ CT Scans/Blood tests)**
Ear Infections			
Sinusitis			
Pneumonia			
Bronchitis			
Meningitis			
Dental Infections			
Bladder/Kidney Infections			
Skin Infections			
Joint Infections			
Gastrointestinal Infections			

12. OTHER MEDICAL/SURGICAL HISTORY: (Please answer all items)

A. List other medical illnesses:

B. Any surgeries:

C. Any ER visits/hospitalizations? For respiratory or allergic reactions? When?

What treatment did he/she receive?

D. For girls, are her menstrual periods regular? Yes ☐ No ☐

Number of days of typical cycle:

13. IMMUNIZATIONS:

A. Are your child's immunizations up to date? Yes ☐ No ☐ **If no**, explain why:

B. Which immunizations listed below has your child received?

☐ Diphtheria	☐ Rubella	☐ Prevnar
☐ Tetanus	☐ Polio	☐ Pneumovax
☐ Measles	☐ HIB	☐ Meningococcal
☐ Mumps	☐ Hepatitis B	☐ Varicella

C. Please list any adverse reactions to any immunizations:

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 for the upcoming season? Yes ☐ No ☐

14. FAMILY HISTORY: (please complete)

Mother's health: age: Father's health: age:
Brother(s)' health: age: Sister(s)' health: age:

Do any family members have a history of the following? ***(If yes, please chack all that apply)***

Illness	**Yes**	**No**	**List Relatives (indicate if outgrown and when)**
Asthma	☐	☐	
Frequent Bronchitis	☐	☐	
Frequent Pneumonia	☐	☐	
Cystic fibrosis or Other Lung Disease	☐	☐	
Hay fever/ Allergic rhinitis	☐	☐	
Chronic Sinus problems	☐	☐	
Hives/ Urticaria	☐	☐	
Eczema	☐	☐	
Migraines	☐	☐	
Insect Allergy	☐	☐	
Drug Allergy	☐	☐	
Food Allergy	☐	☐	
Celiac Disease	☐	☐	
Immune disorders	☐	☐	
Autoimmune disorders (Lupus, thyroid disease, Rheumatoid arthritis)	☐	☐	

Illness	Yes	No	List Relatives (indicate if outgrown and when)
Inflammatory bowel disease	☐	☐	
Early unexplained death in infancy	☐	☐	
Frequent miscarriages	☐	☐	

15. ENVIRONMENTAL SURVEY:

List the cities and states where your child has lived from birth to present:

City **State** **Years** **Effects on Symptoms** (better, worse, no change)

1.
2.
3.
4.

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 ☐ Wall 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: ☐ curtains ☐ drapes ☐ shades ☐ blinds

E. Does your **child's bedroom** 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
☐ Synthetic pillows ☐ Mattresses ☐ Weekly washing of bed linens

H. Do you have any pets (cats, dogs, birds, gerbils, hamsters, etc)?

I. If you have pets, do they enter your child's ☐ bedroom 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 ☐
If yes, which pests? cockroaches ☐ mice ☐ rats ☐ 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?

P. Are there **any other locations(s)** where the symptoms are worse?

Q. How many days has your child missed school/work because of asthma or allergies?

16. COMMENTS: (Are there any other issues you would like to discuss at your visit?)

Signature of Parent or Legal Guardian Date Relationship to Patient:

For the Physician: Reviewed & Confirmed: Date of Visit:

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:

Primary Language

- ☐ Albanian
- ☐ American Sign Language
- ☐ Arabic
- ☐ Armenian
- ☐ Bengali
- ☐ Bosnian
- ☐ Cantonese (Chinese)
- ☐ Creole
- ☐ Croatian
- ☐ ECH
- ☐ Danish
- ☐ English
- ☐ French
- ☐ German
- ☐ Greek
- ☐ Hebrew
- ☐ Hindi
- ☐ Indonesian
- ☐ Italian
- ☐ Japanese
- ☐ Korean
- ☐ Latin
- ☐ Malay
- ☐ Mandarin (Chinese)
- ☐ Persian
- ☐ Polish
- ☐ Portuguese
- ☐ Romanian
- ☐ Russia
- ☐ Serbian
- ☐ Slovak
- ☐ Spanish
- ☐ Swahili
- ☐ Swedish
- ☐ Tagalog
- ☐ Thai
- ☐ Turkish
- ☐ Urdu
- ☐ Vietnamese
- ☐ Yiddish
- ☐ Yugoslavian
- ☐ Other
- ☐ Declined
- ☐ Unknown

Race

- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Other Pacific Island
- ☐ White
- ☐ Other Combination Not Described
- ☐ Declined

Ethnicity

- ☐ Hispanic or Latino or Spanish Origin
- ☐ Not Hispanic or Latino or Spanish Origin
- ☐ Declined

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:

Fax Number: