THE ALLERGY AND ASTHMA CLINIC

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****Please plan on spending 2 hours at this first visit.***

Date: _____

Dear _____,

We are looking forward to seeing you on: _____.

I am enclosing some information about our medical practice. I am also enclosing a medical questionnaire which we ask all our new patients to fill out. It is very important that you complete these forms prior to your appointment and bring them with you when you arrive. This information will help our specialists diagnose and formulate a treatment plan for your allergies.

In order to do allergy testing, we ask all our patients to please stop taking antihistamines for 3 to 7 days prior to their scheduled appointment.

Allergy testing can be an important tool in making a definitive diagnosis as to the cause of your allergies. If antihistamines are in your body's system, the test results may give us a false reading. If you have any questions about any of your medications, please give us a call and one of our nurses will be happy to assist you.

Free parking is available in the Mills Square parking garage. Please bring in your ticket so that we can validate it for you. If you choose, metered street parking is also available.

Please plan to arrive approximately 15 minutes early for your appointment to allow time for check-in and new patient processing.

Thank you for choosing The Allergy & Asthma Clinic. We will do our very best to help you with your allergies.

Sincerely,

Patient Services Representative

Please note our Cancellation Policy, as follows:
Notice of cancellation or re-scheduling is required no less than ***2 business days*** *prior to any scheduled appointment to allow us to give the appointment time to another patient. Cancellations, re-scheduling or "no-shows" with less than* ***2 business days' notice*** *will be subject to a $50.00 charge.*

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Please make sure your child does not take any antihistamines for at least three days prior to his/her appointment. If you have any questions about your child's medications, please call the office and we will be happy to help you.

PEDIATRIC

NAME:_____**DATE**:_____

What would you like for your child to accomplish during your visit at the Allergy and Asthma Clinic?

_____
_____
_____
_____

- **SYMPTOM HISTORY:** Which of the following symptoms is your child currently experiencing or have experienced in the past?

NASAL/THROAT

- ☐ Mucous dripping down the back of your throat (post-nasal drip)
- ☐ Congestion or stuffiness
- ☐ Sneezing
- ☐ Itchy nose/Itchy throat
- ☐ Nosebleeds
- ☐ Runny nose - what color mucous comes out? _____

SINUSES

- ☐ Pain/Pressure
- ☐ Congestion
- ☐ Headache

EARS

- ☐ Itching
- ☐ Fullness
- ☐ Popping

CHEST

- ☐ Cough
- ☐ Chest tightness
- ☐ Shortness of breath
- ☐ Wheezing
- ☐ Cough with exercise
- ☐ Cough with laughter
- ☐ Coughing at night or when you lay down

EYES

- ☐ Watering/tearing
- ☐ Itching
- ☐ Redness
- ☐ Swelling

SKIN

- ☐ Itching
- ☐ Swelling
- ☐ Rashes
- ☐ Hives/Welts
- ☐ Dry skin

HEADACHES

- ☐ No
- ☐ Yes

Which of the above symptoms bother your child the most?

_____
_____

FOR OFFICE USE ONLY

T:_____ P:_____ RR:_____ BP:_____ NURSE:_____

- **SYMPTOM PROGRESSION:**

☐ My child's symptoms have been unchanged for some time.
☐ My child's symptoms have been getting worse over the past few;
☐ week
☐ months
☐ year

My child's symptoms are worse during ;
☐ spring
☐ summer
☐ fall
☐ winter

☐ My child's symptoms are present all throughout the year but flare-up during the _____.

- **PROVOKING FACTORS:**

Do any of these things bring on or aggravate your child's symptoms?
☐ Trees/Pollens
☐ Dust/Molds
☐ Dog/Cat/Other animals
☐ Tobacco smoke
☐ Weather changes
☐ Cold air/Air conditioning
☐ Chemicals/Perfumes
☐ Exercise or Physical exertion
☐ Laughter
☐ Foods: Which ones and what reaction did your child have?_____
_____
_____

EpiPen: ☐ Yes ☐ No

* My child's diet consists of: _____
_____

- **ALLERGY HISTORY:**

Has your child been treated for allergies in the past?

☐ No
☐ Yes
Did he/she see an allergist? ☐ **NO** ☐ **YES** Which doctor?_____
What kind of testing was done? What city?_____
☐ Skin testing
☐ Blood testing (RAST)

When was testing done?_____
What were the results?_____
What type of treatment was recommended?_____
_____
If your child was placed on allergy shots, how long was your child on them them?_____
Did allergy shots help with your child's allergies? ☐ **NO** ☐ **YES**
Did your child have any significant reactions to your allergy shots? ☐ **NO** ☐ **YES,**
please explain_____
_____

- **MEDICATION HISTORY:**

Please list **prescription** allergy medications your child is currently taking. Please include all pills, eye drops, nasal sprays and lung sprays.

MEDICATION DOSE HOW OFTEN DOES IT HELP? SIDE EFFECTS

_____
_____
_____
_____
_____

Please list **over-the-counter** allergy medications (non-prescription) your child is currently taking.

MEDICATION DOSE HOW OFTEN DOES IT HELP? SIDE EFFECTS

_____
_____
_____

Has your child ever taken any of the following antihistamines?

	YES	NO	DID IT HELP ?	SIDE EFFECTS
1. Allegra 30 mg/60 mg/180 mg	____	____	_____	_____
2. Clarinex 5 mg	____	____	_____	_____
3. Claritin/loratadine 10 mg	____	____	_____	_____
4. Zyrtec 5 mg/10 mg	____	____	_____	_____

Please list other medications taken in the past (those not listed above) for your child's allergy or asthma.

_____
_____

How many times, if any, has your child required treatment with oral steroids such as Prelone?_____

- **GENERAL MEDICAL HISTORY:**

Who is your child's pediatrician ? _____ City:_____

Please list the names of your child's other physicians? _____

_____

Is your child allergic to any medications?

☐ No ☐ Yes; he/she is allergic to:_____

What type of reaction did your child have?_____

Has your child been hospitalized, if so, for what condition?_____

Has your child had any ER visits, if so, for what condition?_____

VACCINATIONS: Last flu shot: _____ □ My child has not gotten a flu shot.

My child's vaccinations are up to date: □ Yes □ No

REVIEW OF SYSTEMS:

• **CARDIOPULMONARY**	Chest pain	☐ No	☐ Yes
	Heart Murmur	☐ No	☐ Yes
	Palpitations	☐ No	☐ Yes
• **GENITOURINARY**	Burning on urination	☐ No	☐ Yes
	Frequency of urination	☐ No	☐ Yes
• **GASTROINTESTINAL**	Heartburn	☐ No	☐ Yes
	Abdominal pain	☐ No	☐ Yes
	Diarrhea	☐ No	☐ Yes
	Vomiting	☐ No	☐ Yes
• **PSYCHOLOGICAL**	Mood changes	☐ No	☐ Yes
• **SLEEP PATTERN**	Snoring	☐ No	☐ Yes
	Stop breathing during sleep	☐ No	☐ Yes
	Daytime sleepiness	☐ No	☐ Yes
• **ENDOCRINE**	Heat intolerance	☐ No	☐ Yes
	Cold intolerance	☐ No	☐ Yes
	Excessive thirst	☐ No	☐ Yes
	Low/high thyroid	☐ No	☐ Yes
• **NEUROLOGIC**	Weakness	☐ No	☐ Yes
	Numbness	☐ No	☐ Yes
• **MUSCOSKELETAL**	TMJ Disorder	☐ No	☐ Yes

- **IMMUNOLOGIC** Frequent infections ☐ No ☐ Yes
  Immune disorder ☐ No ☐ Yes

- **HEMATOLOGIC** Easy bruising ☐ No ☐ Yes
  Bleeding gums ☐ No ☐ Yes
  Prolonged bleeding ☐ No ☐ Yes

- **GENERAL** Nausea ☐ No ☐ Yes
  Weight gain ☐No ☐ Yes
  Fever ☐ No ☐ Yes
  Weight loss ☐ No ☐ Yes
  Fatigue ☐ No ☐ Yes

PAST MEDICAL HISTORY:

Has your child been treated for any of the following conditions? Please check all that apply.

☐ Asthma
☐ Gastroesophageal reflux (GERD) ☐ Diabetes ☐ Liver Disease/Hepatitis ☐ RSV
☐ Eczema ☐ Food allergies
☐ Other _____

What medications is your child currently taking for his/her **other medical conditions**?

MEDICATION DOSE HOW OFTEN FOR WHAT CONDITION

_____
_____
_____
_____
_____

- **SURGICAL HISTORY:**

☐ None
☐ Yes, my child has had;
☐ Tonsils Date:_____
☐ Adenoids Date:_____
☐ Ear tube placement
☐ Nasal/Sinus surgery Date: _____ Surgeon:_____
☐ Other:_____ Date:_____

Were there any complications associated with your child's surgery, including with the anesthesia used?
☐ No
☐ Yes; please explain._____

- **IMAGING STUDIES (XRAYS):**

☐ None
☐ Sinuses Date: _____ Results:_____
☐ Chest Date: _____ Results:_____
☐ Other _____ Date:_____ Results:_____

- **FAMILY HISTORY:**

Does anyone in your family have any of these conditions?
☐ Hayfever Who?_____
☐ Sinus problems Who?_____
☐ Skin rashes/facial or lip swelling Who?_____
☐ Asthma Who?_____
☐ No one in my family has allergies.

MATERNAL HISTORY:

☐ Living AGE:_____ Any medical problems? ☐ No ☐ Yes; _____
☐ Deceased at age: Cause of death:

PATERNAL HISTORY:

☐ Living AGE:_____ Any medical problems? ☐ No ☐ Yes;_____
☐ Deceased at age:_____ Cause of death:_____

_____

- **ENVIRONMENTAL HISTORY: HOME**

Do you live in a:
☐ House
☐ Apartment
☐ Townhouse/Condo/Duplex

Does anyone in the house smoke? ☐ No ☐ Yes
Is there smoking in the bedroom? ☐ No ☐ Yes
Do you have any pets? ☐ No ☐ Yes, we have, _____
Are they allowed to come in the bedroom? ☐ No ☐ Yes
Are they bathed? ☐ No ☐ Yes
What type of heating do you have in the house?
☐ Central furnace with forced-air heating
☐ Wall heaters
☐ Radiant-heating system
How old is the system?_____ years old.
☐ The heating system is new.
Has the system been professionally cleaned?
☐ Yes, how long ago?_____
☐ Not since we've lived in the house.
☐ I don't know.
Are there special allergy filters in the heating system? ☐ No ☐ Yes
Do you have air-conditioning? ☐ No ☐ Yes

BEDROOM

Does your child have carpeting in his/her bedroom? ☐ No ☐Yes
There is _____ in the bedroom.

Does your child sleep on any type of feather bedding?
☐ No
☐ Yes ☐ Pillow ☐ Down comforter ☐ Feather bed

Does your child sleep on a waterbed? ☐ No ☐ Yes
Does your child have an air-purifier in his/her bedroom? ☐ No ☐Yes, it runs _____hours a day.

Please answer the questions below if your child is frequently bothered by skin rashes or hives.
Current Soap:_____
Are moisturizers used daily? □ No
□ Yes , what product?_____
What other skin care products do you on your child use on a regular basis?_____
What laundry detergent is used at home?_____
Do you use fabric softeners? □ No
□ Yes, what product?_____

_____
_____

ADDITIONAL COMMENTS:
Please use this space to expand on any issues you would like us to be aware of:
_____
_____
_____
_____