LAKE ALLERGY,
ASTHMA & IMMUNOLOGY

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NEW PATIENT QUESTIONNAIRE: PEDIATRICS

INSTRUCTIONS: Carefully complete all 3 pages of this form in full. Relate all answers to patient's own experience.

NAME: _____ AGE: _____ DOB: _____ DATE: _____

Referred by: _____ Pediatrician: _____

Circle the allergy problem(s) that you have:

Runny / stuffy nose (hay fever)	Sinusitis	Insect allergy	Eye or ear problems
Asthma	Eczema / rash	Drug allergy	Headache
Cough	Hives or swelling	Food allergy	Frequent infections

The major problem(s) you wish to discuss is: _____

List **all** prescription and over the counter medications you are now using (name & dosage):

_____

_____

_____

List medications you have tried in the past for your allergy problems: _____

_____

I. Symptoms

Eyes:	Itch___	Swell___	Burn___	Tear___	Discharge___	Dry___
Ears:	Itch___	Fullness___	Popping___	⇓ hearing___	Pain___	Ringing___
Nose:	Sneeze___	Itch___	Runs___	Stuffy___	Mouth breather___	
	Snoring___	Headache ___	Decreased smell___		Decreased taste___	
Throat:	Itch___	Sore___	Post nasal drip___	Throat clearing___	Swelling___	
Chest:	Cough___	Phlegm___	Hoarseness___	Asthma diagnosed by a physician___		
	Wheezing___	Heartburn___	Chest Tightness___	Shortness of breath with exercise___		
	Nighttime cough/wheezing___					
Skin:	Eczema___	Hives___	Swelling___	Rashes__where on body?_____		

A. Respiratory allergies

1. Age of onset of your hay fever _____, and/or asthma _____
2. Do you have daily symptoms? _____
3. What time of year are your allergies or asthma worse? (please list months) _____
4. What time of day or night is the worst for your symptoms? _____
5. Does any particular exposure (e.g.cat, smoke, weather change, work, school) make you worse?(list)

   _____
6. Do you get sinus infections (yellow/green nasal drainage, pain, etc.)? _____How often? _____
   How is it usually treated? _____
7. Have you had nose or sinus surgery, tonsils/adenoids removed, or ear tubes?_____
9. Have you ever been hospitalized for your asthma? _____ Emergency room?_____

B. Insect allergy

Have you had a severe allergic reaction to a stinging insect (bee, wasp, yellow jacket, hornet, fire ant)? (explain)_____

C. Drug allergies

Please list all drugs, reaction, and approximate date: _____

D. Food allergies

Please list all foods and reaction they cause: _____

_____

E. Have you had hives (welps) before? (when and for how long)_____

F. Have you had eczema (red, scaly, itchy skin) previously?_____

G. Are you sensitive to latex or rubber products? (explain) _____

II. Previous Allergy Evaluation and Treatment

A. Name of allergist and city_____

B. Were you tested for allergies by skin test or blood test? _____When _____ Results: _____

_____

C. Have you received allergy shots? _____When, how long: _____

D. Have you ever had steroid pills (dosepak, Prednisone) or shots (cortisone)? _____When _____

III. Past Medical History

A. Medical problems: (please circle)

	Diabetes	Thyroid problem	Heart disease
High blood pressure	Abnormal chest x-ray	ADD/ADHD	
Stomach ulcer	GERD (acid reflux)	Hiatal hernia	Depression
Cancer	HIV / AIDS	Other: _____	

B. Please list all important operations and other hospitalizations that you have had: _____

_____

C. Have you ever had a blood transfusion? _____

D. Have you experienced recurrent sore throats, bronchitis (how often) _____

Or severe infections (kidney, meningitis, pneumonia) _____

E. Have you ever had a chest x-ray, sinus x-ray, breathing test, blood tests? Comment on results _____

F. Do you receive the flu vaccine yearly?_____

G. Are your vaccinations up to date? _____

IV. Family History

A. How many siblings do you have? ____ brothers _____ sisters

B. Do your close relatives have any of the allergy problems mentioned above? (list and comment)

_____

C. Are there any hereditary diseases or other disorders that seem to occur frequently in your family? _____

_____

V. Personal and Environmental History

A. Do you presently smoke? (how much and how long) _____

B. Have you ever smoked? (how much and how long) _____ Quit: ____ years ago

C. Are there smokers other than yourself at home? _____, how many _____

D. Do you have animals at home? (type and for how long) _____

E. Do you have mostly wall-to-wall carpeting in your home? _____In your bedroom? _____

F. What school and grade are you in? _____

G. Has your problem caused you to miss school? _____

H. How long have you lived in the area? _____Lived previously in?_____
I. Do you symptoms become better or worse on vacation? _____
J. Does a change in the weather influence your symptoms? _____
L. What are your daily activities (school, daycare, etc)? _____
M. How many other people live in your home? _____

VI. Review of Systems: Do you have any of the following? (check)

General
____ weight loss
____ fever
____ night sweats
____ loss of appetite
____ dry mouth
____ snoring

Eyes and ears
____ dry eyes
____ change in vision
____ trouble hearing
____ ringing in ears

Endocrine
____ cold / heat intolerance
____ increased thirst
____ frequent urination

Gastrointestinal
____ nausea / vomiting
____ diarrhea
____ change in bowel habits
____ trouble swallowing
____ heartburn

Cardiovascular
____ chest pain
____ chest pain with exercise
____ calf pain with exercise
____ ankle swelling

Psychological
____ fearful, anxious
____ excessive worry

Skin
____ recurrent skin infections
____ skin rashes

Blood
____ anemia (low blood)
____ bleed or bruise easily
____ swollen lymph nodes

Musculoskeletal
____ morning joint stiffness and aching
____ painful, swollen joints
____ muscle tenderness or pain
____ muscle weakness

Gynecological
____ excess bleeding
____ changes in menstrual cycle

Neurological
____ weakness /clumsiness
____ tingling/numbness of extremities

VII. Additional Information
Anything else you want to discuss during your initial visit?
_____
_____
_____
_____
_____