The Children's Hospital of Philadelphia

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DIVISION OF ALLERGY AND IMMUNOLOGY

Allergy and Asthma

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NEW ALLERGY AND ASTHMA PATIENT QUESTIONNAIRE

Patient Name: ____________________________ **Birth Date:** __/__/__

REFERRAL

Why are you here today? ____

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Who referred you to us? ____

MEDICATIONS (Please list)

Medication	Dose/Strength	Directions for Use

PHARMACY INFORMATION

Name: ____________________ State, & Zip: ______________

Address: ____________________ Phone ______________

Town: ______________________________ Fax Number: ____________________

A. - - - - - - - - - - - - - - - - PAST MEDICAL HISTORY- - - - -- - - - - - - - - - - - - - - -

BIRTH HISTORY

Birth Length: Birth Weight: Birth Head Circ.:
Discharge Weight: Gestational Age: Delivery Method:
Primary Nourishment Method:
Additional Comments:

PAST HOSPITALIZATIONS

Hospitalization Date: Reason:
Hospitalization Date: Reason:

PAST SURGICAL HISTORY

Date:

MEDICAL HISTORY

DRUG ALLERGIES OR REACTIONS

- ☐ Penicillin/Amoxicillin
- ☐ Food: ______________________________
- ☐ Latex
- ☐ Blood products: ____________________
- ☐ Other medication_______________
- ☐ Radiocontrast material (X-ray dye)
- ☐ Adhesives
- ☐ Other: ________________________

OTHER MEDICAL HISTORY

Varicella (chickenpox) infection? YES NO
Varicella immunization? YES NO
Are your child's immunizations up to date? YES NO
Tuberculosis skin test: Normal YES NO
Previous Allergy/Immunology/Pulmonary evaluation? YES NO By Whom?

B. FAMILY HISTORY

	(M)Mother	(F)Father	(S)Siblings	(O)Other
Asthma	_____	_____	_____	_____
Allergy	_____	_____	_____	_____
Autoimmune disease	_____	_____	_____	_____
Birth defect	_____	_____	_____	_____
Blood (Sickle cell, other)	_____	_____	_____	_____
Cancer	_____	_____	_____	_____
Childhood deaths	_____	_____	_____	_____
Chronic Lung problems	_____	_____	_____	_____
Cystic fibrosis	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____
Drug Allergy	_____	_____	_____	_____
Eczema	_____	_____	_____	_____
Food Allergy	_____	_____	_____	_____
Gastroesophageal reflux	_____	_____	_____	_____

Hereditary angioedema	_____	_____	_____	_____
Hayfever /Allergic rhinitis	_____	_____	_____	_____
Heart-Early heart attack	_____	_____	_____	_____
Hives	_____	_____	_____	_____
Hypertension high blood pressure	_____	_____	_____	_____
Immunodeficiency	_____	_____	_____	_____
Kidney	_____	_____	_____	_____
Mental Retardation	_____	_____	_____	_____
Nose	_____	_____	_____	_____
Premature Death	_____	_____	_____	_____
Psychiatric	_____	_____	_____	_____
Seizures	_____	_____	_____	_____
Skin Disease	_____	_____	_____	_____
Substance Abuse	_____	_____	_____	_____
Sudden Death	_____	_____	_____	_____
Tuberculosis	_____	_____	_____	_____

C. - SOCIAL, HOME AND SCHOOL HISTORY- - - - - - - - - - - - - -

1. PATIENT LIVES WITH (Circle all that apply)

Mother   Father   Spends time between parents' homes   Siblings #_______________

Grandparents   Other__________

2.HOME

Smokers in home	YES NO	If yes, whom and where?
Smokers at other location?	YES NO	If yes, where?
Pets in home	YES NO	If yes, type of pet(s)
Pets at other location?	YES NO	If yes, where and type?
Pets allowed in child's room	YES NO	
Previous owners had pets	YES NO	If yes, type of pet(s)
Carpeting from prior owners	YES NO	

Flooring in patient's bedroom

Hardwood   Linoleum   Carpet   Tile   Concrete

Circle any cooling system(s) that applies to your home

Central air conditioning   Wndow unit air conditioning   Fan

Circle any heating system(s) that applies to your home

Electric   Radiator   Forced air   Fireplace   Wood stove

Environmental Controls measures done to decrease allergens in your home:

Allergy covers for mattress	Allergy covers for pillows	Hot water washing of bedding weekly
HEPA filter/other filter	Mold eradication	Removal of pets from home
Removal of pets from bedroom	Removal of carpetting from bedroom	Decreased dust collectors in bedroom

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3. SCHOOL/CHILDCARE (circle all that apply)

Daycare	Preschool	School
Goes to babysitter’s home	In-home babysitter	Other:__________________

D. - - - - - - - - - - - - - -- - - - - - - - GENERAL HEALTH REVIEW -- - - - - - - -

1. CHEST (Circle all that apply)

Chest pain | Mucus in the chest | Wheezing | Shortness of breath
Bronchitis | Pneumonia | Croup | Other
Cough that won't go away
Cough, wheeze, or SOB with exercise, emotions, or cold air

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2. Heart and Blood Pressure (Circle all that apply)

Abnormal or rapid heart rate | Heart murmur | High blood pressure | Other

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3. Mouth and Throat (Circle all that apply)

Itching mouth/throat | Post nasal drip | Throat clearing | Frequent sore throat
Large tonsils or adenoids | History of croup

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4. Nose (Circle all that apply)

Runny | Itchy | Sneeze | Stuffy
Mouth breathing | Snoring with Apnea | Snoring without Apnea | Sniffling
Sinusitis

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5. Eyes (Circle all that apply)

Itching | Redness | Tearing | Contact lens wearer
Swelling | Other:

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6. Ears (Circle all that apply)

Frequent ear infections | Fluid in ears | Tympanostomy tubes | Hearing loss
Other

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7. Skin (Circle all that apply)

History of eczema | Hives | Swelling
Location:

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8. Diet and Food Allergy

Was your child breastfed?
What formula(s) was your child fed? List:
Below is a list of foods. Please check each food that causes your child symptoms.
Be prepared to describe those symptoms at the visit.

List of foods that have caused symptoms: (Circle all that apply)

Milk	Egg	Soy	Peanut
Wheat	Fish	Shellfish	Beef
Chicken	Pork		
Turkey	Grains	Fruit	Citrus
Vegetables	Beans	Sesame	Treenuts
Tomato	Chocolate	Gelatin	Spice

Other
Comments:

9. Digestive System (Circle all that apply)

Failure to thrive	Poor appetite	Frequent spit-up	Heartburn
Choke/gag w/eating	Choke/gag w/o eating	Vomiting	Nausea
Abdominal pain/cramping	Diarrhea	Constipation	Reflux
Greasy or large stools			

Comments:

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10. Genital and Urinary Systems (Circle all that apply)

Painful urination	Bedwetting	Frequent urination	Difficulties with menstruation
Blood in urine	Other:		

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11. Neurological (Circle all that apply)

Frequent headaches Seizures Migraines Other:

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12. Psychiatric (Circle all that apply)

Attention deficit (ADD) Behavioral Problems Anxiety Other:

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13. Endocrine (Circle all that apply)

Diabetes	Frequent urination	Thyroid Problem	Excessive thirst
Intolerance to heat or cold	Unexplained weight loss or gain		Other

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14. Musculoskeletal (Circle all that apply)

Swollen joints	Fractures	"Growing Pains"	Other:
Joint pain			

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15. Development (Circle all that apply)

Normal Delayed globally Delayed speech Delayed motor

Other:

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16. Hematologic/Oncologic (Circle all that apply)

Anemia	Sickle Cell	Bleeding Disorder	Cancer
Leukemia	Lymphoma		

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17. Immunologic (Circle all that apply)

Immune Deficiency Autoimmune Disease