(pedi)

Patient Name:______________________ Date: _______________
date of birth:____________

I am being seen on:
a) self referral _____ b) physician referral from Dr. ____________________

Please share the main reasons for your office visit today (check all those that apply):
a) Allergic rhinitis (runny and/or stuffy nose) ______
b) Allergic conjunctivitis (red, itchy eyes) ______
c) Asthma ______
d) Bronchitis ______
e) Atopic dermatitis (eczema) _______
f) Nasal polyps _______
g) Urticaria (hives) _______
h) Frequent sinus infections _______
i) Other __________________________

What you would like to accomplish today?
a) Review my current illness and treatment ______
b) Obtain allergy testing ______
c) Obtain information on asthma diagnosis and treatment ______
d) Other ____

HISTORY OF PRESENT ILLNESS (please fill in all sections which apply to you or your family member):

My symptoms began :
____ days ago
____ weeks ago
____ months ago
____ years ago

My symptoms are:
Seasonal: (Worse during a certain season? Check which season is worse)
Spring ____
Summer ____
Fall ____
Winter ____
Perennial (equal all year) with no seasonal change ____
Perennial (equal all year) with seasonal exacerbations in the:
Spring____ Summer ____ Fall____ Winter ____

Please check which of the following symptoms are present:

NOSE:
Nasal congestion (blockage) ______
Mouth breathing at night: ______
Itchy nose: ______
Bloody nose: ______
Sneezing: ______
Snoring: ______
Poor sense of smell: ______
Drippy/runny nose: ______
Drainage in back of throat: ______

LUNGS:
Shortness of breath: ______
Wheezing: ______
Cough: ______

EYES:
Redness: ______
Watering: ______ _
Sensitivity to light: ______
Itching: ______

HEADACHE:
Location (front, side, back) __________
Quality (sharp, dull, achy) __________

EARS:
Itching: ______
Frequent infections: ______
Congestion (stuffiness) ______

SKIN:
Hives: ______
Eczema:
Swelling of face: ______

Triggers that I know worsen my symptoms include:

No known environmental triggers _____

Specific environmental triggers:
- Indoor dust: _____
- Outdoor dust: _____
- Mold spores: _____
- Animal dander
  - cat ____
  - dog ____
  - other ____
- All pollens ____
  - tree pollen ____ grass pollen ____ weed pollen ____ other pollen ___

Non-specific environmental triggers:
- Weather changes
  - any weather change ____
  - hot and dry weather ______
  - cold and wet weather ____-
- Tobacco exposure ____
- Perfumes and propellants ____
- Other ______________________
____

ALLERGY HISTORY:

Allergy testing has:
- never been pursued ____
- is scheduled ____
- has previously shown no allergies ____
- allergy to:
  - pollen ___
  - dust ___
  - mold ___
  - pets ___
  - other _________________

I have never been on allergy injections ____
I am currently on allergy injections ____
These began ____months ago
____years ago

I previously received allergy injections ____
These were given ____years ago
I continued these for ____years

Have you had experience with any of the following medications? If so, did they help?

TYPE OF MEDICATION	RESULT GOOD	RESULT BAD	EXAMPLES (i.e., Claritin, Flonase, etc.)
Antihistamines	_____	_____	_____________________
Decongestants	_____	_____	_____________________
Antihistamine/Decongestants	_____	_____	_____________________
Nose sprays	_____	_____	_____________________
Eye drops	_____	_____	_____________________

Have you had allergic reactions to medications or foods?

DRUG REACTIONS:

	Name of medication	Type of reaction (skin, respiratory, stomach symptoms, etc.)
1)	____________________	____
2)	____________________	____ _
3)	____________________	____

____

FOOD REACTIONS

	Name of food	Type of reaction
1)	______________	____
2)	______________	____
3)	______________	____

___________ __________________________________

PAST MEDICAL HISTORY

Hospitalizations and/or surgery:

Age or year	for
_______	____
_______	____
_______	____
_______	____

Other chronic health conditions (Please specify)

____

____

Please list *all* of your current medications:

	Name of medication	Route, dose & frequency (i.e., 10mg each morning)	Indication (i.e., for blood pressure)
1)	__________________________	________________	______________________________
2)	__________________________	________________	______________________________
3)	__________________________	________________	______________________________
4)	__________________________	________________	______________________________
5)	__________________________	________________	______________________________

FAMILY HISTORY (Please check if your family member is or has been affected by the following illnesses):

	Asthma or Chronic bronchitis	Allergic rhinitis (hayfever)	Atopic dermatitis (eczema)	Urticaria (hives)
Mother	_____	_____	_____	_____
Father	_____	_____	_____	_____
Brother	_____	_____	_____	_____
Sister	_____	_____	_____	_____
Other relatives______________	_____	_____	_____	_____
______________	_____	_____	_____	_____

SOCIAL HISTORY:

Parents' marital status

Married ____
Separated ____
- lives with mother ___
- lives with father ___
- other _____________

Divorced ____
- lives with mother ___
- lives with father ___
- joint custody ___
- other _____________

Members of household

mother ___
father ___
____ brother(s) (how many)
____ sister(s) (how many)
other(s) _______________

Name of daycare/school ____________________ Grade level/classification ________________

daycare/preschool ____
grade school ____
middle school ____
high school ____

Extracurricular activities/hobbies:
sports ____
band/choir/orchestra ____
cheerleading ____
4-H ____
other ________________

Employment (if applicable):
where ________________
position ________________

TOBACCO HISTORY:

Cigarette smoker/or exposure (check all that apply):

Exposure to cigarette smoke _____

Non – smoker _____
Smoker _____ pack/day for _____ years

Ex-smoker _____
quit how long ago
weeks _____
months _____
years _____

Other tobacco use ________________

ENVIRONMENTAL HISTORY:

The patient lives in a(n):
house ____
apartment ____
other ________________

The home is in:
town ____
the country ____
other ____________

Indoor exposure to the following is present:

Pets:
cats _____
dogs _____
other __________________

Heating/Air-conditioning:
central heat/air ____
evaporative cooler ____
gas heat/furnace ____
other ________________

Bedding:
boxspring mattress ____
waterbed ____
other ________________

Carpeting in bedroom ____

ASTHMA ***(Please skip this page if you have never had breathing problems)***

Asthma has:

never been previously diagnosed, but is suspected _____
been diagnosed in childhood _____ at age ____
been diagnosed in adulthood _____ at age ____

My compliance with medications:

is always excellent ____
is intermittently good ____
is poor because: ____
I hate to take any medication ____
I am concerned about side effects ____
medications are too expensive ____
medications have not helped me in the past____
other ________________________________

I currently use the following:

a spacer attached to my inhaler ____
a peak flow meter to measure breathing ____
a written asthma action plan ____

Triggers for my asthma symptoms include:

no obvious exposures ____
pollens ____
animal dander ____
dust ____
cigarette smoke ____
weather change ____
respiratory infections/colds ____
sinus infections ____
exercise ____
other______________

Asthma medications I have had previous experience with include:

ASTHMA RELIEVERS	Response Good	Bad
Quick-acting		
Albuterol	____	____
Xopenex	____	____
Maxair	____	____
Atrovent	____	____
Combivent	____	____
Long-term		
Foradil	____	____
Serevent	____	____
ASTHMA CONTROLLERS		
Inhaled steroids		
Aerobid	____	____
Azmacort	____	____
Beclovent	____	____
Flovent	____	____
Pulmicort	____	____
Vanceril	____	____
Leukotriene modifiers		
Singulair	____	____
Accolate	____	____

Leukotriene modifiers (cont'd)	Good	Bad
Zyflo	____	____
Mast cell stabilizers		
Intal	____	____
Tilade	____	____
Combination drugs		
Advair	____	____
Symbicort	____	____
Theophylline		
Slo-Bid	____	____
UniDur	____	____
Uniphyl	____	____
Oral Steroids		
Prednisone	____	____
Medrol	____	____
Prelone	____	____
Pediapred	____	____

*Other medications*______________________________