Allergy, Asthma & Immunology
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Allergy Survey/ Medical History

Appointment Date: _____

Child's name: _____ Date of birth: _____ Age: _____

Parent's names: _____ Phone: _____

Home Address: _____

Name of child's doctor: _____

1. Allergy history:
   A. Briefly state your child's problem: _____

   B. Describe typical symptoms: _____

   _____

   C. Date or age of onset: _____

   D. What factors do you think may bring on worsening? (Check those that apply)

   ___Foods ___Odors; cosmetics ___Animals ___House dust
   ___Drugs ___Exertion (exercise) ___Leaves ___Tree pollen
   ___Smoke ___Temp. Changes ___Fumes ___Other
   ___Infections ___Dampness or rain

   E. When are the symptoms more severe?

   ___Fall ___Night ___Home (indoors) ___Other places _____
   ___Winter ___Day ___Home (outdoors)
   ___Spring _____ ___School
   ___Summer

   F. How many school or day care days has your child missed in the past year? _____

   G. Has your child been evaluated by an allergist in the past? ___Yes ___No

   H. List known allergies: _____

   Medicine Allergy, including antibiotics: _____

   Food Allergy:_____

   Insect Allergy:_____

2. Medications:

1. Antihistamines (Zyrtec, Allegra, Claritin, Benadryl): _____
2. Decongestants (Sudafed, Entex): _____
3. Antibiotics: _____
4. Wheezing medicine (bronchodilators): _____
5. Steroids (prednisone, Decadron): _____
6. Sprays, mists, nose drops: _____
7. Allergy injections: _____
8. Gamma globulin: _____
9. Other: _____
10. List any medicine your child takes for other conditions: _____

_____

3. Child's past medical history:

A. Birth Weight: _____ Gestational age in weeks:_____

Complications: _____

B. Illnesses: (Yes, No, Frequency, Ages occurred)

Ear infections: _____

Tonsillitis: _____

Colds: _____

Sinusitis: _____

Bronchitis: _____

Pneumonia: _____

Skin rashes (other than diaper rash or "heat rash"): _____

Thrush: _____

C. Hospitalizations: (Where, When, for what reason?)

_____

_____

D. Surgery: _____

E. Immunizations: Up-to-date for age? ___Yes ___No

F. Other health problems: _____

_____

4. Feeding history:

Formula taken by your child: _____

What foods (if any) do you not feed your child? _____

Why? _____

5. Environment: (Check or circle appropriate selection)

With whom does the child live? _____

A. ___House (years old) ___Mobile Home (years old) ___Apartment (years old)

B. Heating: ___Central ___gas ___electric ___space heaters ___steam heat

C. Air Conditioning: ___Central ___Window units

D. Humidifier: ___Room ___central Air filter: ___Room ___central

E. Ceiling fans: (Which rooms) _____

F. Floors: Living areas: ___Carpet ___Wood ___Tile ___Concrete
Patient's Bedroom: ___Carpet ___Wood ___Tile ___Concrete
Type of mattress: ___regular ___feather ___crib ___other
Type of pillows: ___polyester ___foam ___feather ___other
Are there allergy/plastic covers on the mattress? ___Yes ___No
Pillow encasings? ___Yes ___No
Type of blankets: ___Cotton ___polyester ___wool ___Down ___Other _____
Type of curtains and bedspreads: _____
Are there stuffed toys in the room? ___Yes ___No
Any stuffed toys in the bed? ___Yes ___No

G. Animal contact (type of animals, how many):

Inside your home: _____
Outside your home: _____
Relative or friend's home: _____

H. What surrounds your home? ___other homes/neighborhood ___fields ___factory ___other _____

I. Is mold or mildew (smell or dampness) a problem in your home? ___Yes ___No
Any water leaks? ___Yes ___No If so, where? _____

J. Does your child attend a day care center, preschool or Headstart? ___Yes ___No

If so, how many days per week? _____; hours per day _____.
Approximately how many other children also attend the day care center? _____

K. Do any smokers live in the home? ___Yes ___No Whom? _____
Do they smoke inside the home? ___Yes ___No
In the car? ___Yes ___No

L. Fireplace/woodstove used: ___Yes ___NO

6. <u>Family history:</u>

Do any members of the immediate family have any significant health problems? _____

_____

How many brothers are there? (Ages) _____ How many sisters? (Ages)_____

Please Check All That Apply

	MOTHER	**FATHER**	**BROTHER/SISTER**	**OTHER**
ASTHMA				
CHILDHOOD ASTHMA				
HAY FEVER				
ECZEMA				
FOOD ALLERGIES				
DRUG ALLERGIES				
REPEATED INFECTION				
OTHER				