



Patient Allergy History Questionnaire

Child's Name _____ Date of Birth ____/____/____

What is the main reason your child is being seen in the Allergy Clinic? _____

1. COUGH OR POSSIBLE ASTHMA (if none go to section 2)

Check any of the following that are problems for your child:

- Cough Wheeze Shortness of breath Chest tightness

How old was your child when he/she first began having these chest symptoms? _____

Are there a certain times of year when these asthma/chest symptoms are worse? Yes No

If yes, which months? _____

Check any of the following that make the asthma/chest symptoms worse: Animals, which animals: _____

- Dust Grass Smoke Fumes Cold air Windy weather

- Respiratory infections ("colds") Exercise Other (list) _____

Has your child ever had to stay overnight in the hospital because of asthma/chest symptoms? Yes No

If yes, approximately how many times: _____ Date of last hospital stay: _____ How many ICU stays _____

Has your child ever had to go to the ED or urgent care because of asthma/chest symptoms? Yes No

If yes, how many times in the past 12 months _____

Has your child ever had pneumonia? Yes No If yes, How many episodes? _____

How many school days has your child missed this school year due to these symptoms? _____

How many days of work have you missed due to your child's symptoms? _____

How many nights has your child awoken from sleep because of wheezing of cough in the last 2 weeks? _____

How many days or nights in the past 2 weeks has your child needed to use an inhaler or nebulizer to treat wheezing or cough? _____

Does your child have a peak flow meter: Yes No If Yes, Best Peak Flow: _____

2. NOSE OR EYE SYMPTOMS (If none go to section 3)

Check any of the following that are problems for your child: Runny nose Stuffy nose Itchy nose Sneezing fits

- Watery eyes Red eyes Itchy eyes Itchy ears Itchy throat Post nasal drip Throat clearing

How old was your child when he/she first began having these nose/eye symptoms? _____

Which seasons are these nose/eye symptoms occur? Spring (March to May) Summer (June to August)

- Fall (September to November) Winter (December to February) All the time

Check any of the following that make the nose/eye symptoms worse: Cats Dogs Dust

- Grass Smoke Fumes Cold air Other: _____

Has your child ever had allergy skin testing before? No Yes

If yes, check those tests were positive: Dust Mite Pollen Mold Animal Hair Foods

Has your child ever been on allergy shots before? Yes No

3. ECZEMA (CHRONIC DRY ITCHY SKIN)(if none go to section 4)

How old was your child when he/she first began having eczema? _____

Check Body Parts with eczema: Face Scalp Arms Legs Chest Abdomen Back

Are there any foods that seem to worsen the eczema? Yes No If yes, which foods? _____

4. FOOD REACTIONS (if none go to section 5) - List foods to which you suspect your child is allergic and check reaction type

Food	Rash/hives/ eczema	Vomiting/ diarrhea	Facial Swelling	Difficulty breathing	Shock	Other

How long after eating the food did the reaction occur (check one): within 2 hours 2-24 hours greater than 24 hours

Did your child go to the emergency room or acute care for the reaction? Yes No

Did your child require oral medicine or a shot to treat the reaction? Yes No

How old was your child when he/she had the first suspected reaction to the food? _____

When was your child's most recent reaction to the food? _____

Has your child ever had skin tests or blood tests for food allergy? Yes No

If yes, which tests were positive? _____

Medications (please check all your child has used or tried):

Inhalers: Flovent Qvar Pulmicort Advair Serevent Foradil
 Albuterol Asmacort Asmonex Other: _____

Nasal Sprays: Nasonex Rhinocort Nasocort Atrovent Afrin Neosynephrine

Antihistamines: Allegra Benadryl Zyrtec Atarax Claritin Clarinex

Skin preparations: Hydrocortisone Aclovate Triamcinolone Elocon Elidel
 Protopic Cutivate Other: _____

Nebulized Medications: Albuterol Xoponex Pulmicort Atrovent

List any bad reactions your child has had to any medication: _____

List all medicines your child is currently taking for any reason (include over the counter, herbal, and homeopathic remedies)

ENVIRONMENT

Check any pets that you have: Dogs Cats Hamster Guinea Pig Other: _____

Do any members of your household smoke: Yes No

About how old is your home? _____ years

Has there been any water damage or mold present in the home? Yes No

Where does your child sleep: Own bed with sib or parent Other (such as sofa)

Has your child had a bad reaction (hives, wheezing, swelling, paleness, etc.) to: bee sting wasp sting

hornet sting ant sting latex (balloons, rubber, or elastic)

FAMILY HISTORY (Check all that apply) :

Relative	Asthma	Nasal allergy	Eczema	Food allergy	Hives
Mother					
Father					
Brother or sister					

List other diseases that run in the family: _____

Past History

List by date any hospitalizations for problems other than asthma: _____

List any surgeries and dates: _____

List your child's birth weigh: _____ Was your child premature? No Yes

List any newborn problems: _____

Review of Systems (Where asked check yes or no)

Skin: Has your child had hives? Yes No If yes, how many days did the hives last? _____

HEENT: How many ear infections has your child had in the last year? _____

How many sinus infections has your child had in the last year? _____

Has your child had PE (ear) tubes placed? Yes No

Does your child have difficulty swallowing, pain with swallowing, or heartburn? Yes No

Heart: Has your child ever had a heart murmur or irregular heart beat? Yes No

Has your child ever fainted or passed out? Yes No

GI tract: Does your child have frequent loose stools? Yes No

Has your child had any liver problems, such as hepatitis? Yes No

Nervous system: Has your child had seizures? Yes No

List any learning problems your child has: _____

Kidneys: Does your child have any kidney problems? Yes No

To the best of my knowledge, the information provided here is correct:

Parent/Guardian

Provider

Date ____/____/____ Time:_____

Date ____/____/____ Time:_____