Food Allergy Center of Florida

Windom Allergy, Asthma & Sinus

SCR Sarasota Clinical Research

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NEW PATIENT QUESTIONNAIRE: PEDIATRICS

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

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

Referred by: _____ Pediatrician: _____

Circle the problem(s) that bring you to *Windom Allergy*:

Runny / stuffy nose (hay fever)	Sinusitis	Insect allergy	Eye or ear problem
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 using NOW: _____

_____

List *allergy* medications you have used *in the past*: _____

_____

I. Symptoms (check all that apply)

Eyes: ☐ Itch ☐ Swell ☐ Burn ☐ Tear ☐ Discharge ☐ Dry

Ears: ☐ Itch ☐ Fullness ☐ Popping ☐ Decreased Hearing ☐ Pain ☐ Ringing

Nose: ☐ Sneeze ☐ Itch ☐ Runny ☐ Stuffy ☐ Mouth Breather
☐ Snoring ☐ Headache ☐ Decreased Smell ☐ Yellow/Green Drainage

Throat: ☐ Itch ☐ Sore ☐ Post Nasal Drip ☐ Throat Clearing ☐ Swelling

Chest: ☐ Cough ☐ Phlegm, color/amount_____ ☐ Asthma diagnosed by a physician
☐ Wheezing ☐ Chest tightness ☐ Heartburn ☐ Shortness of breath with exercise
☐ Nighttime wheezing/cough

Skin: ☐ Eczema ☐ Hives ☐ Swelling ☐ Rashes. If so, where on body? _____

A. *Respiratory allergies*

1. Age of onset of your hay fever _____, and/or asthma _____.
2. Do you have daily symptoms? _____
3. Does any particular exposure (cat, dust, smoke) make you worse? (list)_____
4. Do you get sinus infections (yellow/green nasal drainage, pain, etc.)? _____ How often? _____
   How is it usually treated? _____
5. What time of year are your allergies worse? (please list months) _____
6. What time of day or night is the worst for your symptoms? _____
7. Have you ever been hospitalized for your asthma?(when) _____ Emergency room? _____
8. Have you had sinus surgery, tonsils/adenoids removed or ear tubes? _____

B. *Drug allergies*
Please list all drugs, reaction and approximate date: _____

_____

C. *Insect allergy*
Have you had a severe allergic reaction to an insect sting (wasp, yellow jacket, hornet, fire ant)? (explain) _____

_____

D. *Food allergies*
Please list all foods and reaction they cause: _____

Were you nursed or bottle fed? _____ Colic or reflux with formulas? _____

E. Have you had *hives* (welts) before? (when, 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. Were you put on allergy shots? _____ When, how long: _____

D. Have you ever had steroid pills / syrup (dosepak, Orapred, Prelone, Pediapred)? _____ When _____

III. Past Medical History

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

B. Other medical problems: (please circle) Diabetes Heart disease Hiatal hernia
Abnormal chest x-ray Hepatitis ADD/ADHD Other _____

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

_____

F. Are your vaccinations up to date? _____

G. Do you receive the flu vaccine yearly? _____

IV. Family History

A. How many siblings do you have? ____ brothers, _____sisters.

B. Do your close relatives have any of the allergy problems we've covered 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. Are there smokers at home? _____ How many? _____

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

_____

C. Do you have mostly wall-to-wall carpeting in your home? _____ In your bedroom? _____

D. What school and grade are you in? _____

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

F. How long have you lived in the area? _____ Lived previously in _____

G. Do your symptoms become better or worse on vacations or at the beach? _____

H. Does a change in the weather influence your allergy symptoms? _____

I. What are your daily activities? (school, daycare, etc.) _____

J. How many other people live in your home? _____

VII. Review of Systems

Do you have any of the following? (check)

General
____ weight loss
____ fevers
____ night sweats
____ loss of appetite
____ swollen lymph nodes
____ dry mouth
____ snoring

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

Skin
____ skin rashes
____ recurrent skin infections

Gastrointestinal
____ nausea / vomiting
____ diarrhea
____ frequent stomach aches

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

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

Psychological
____ fearful, anxious
____ excessive worry
____ trouble sleeping
____ depression

VIII. Additional Information

Anything else you want to discuss during your initial visit? _____

_____

_____

_____

_____