BOULDER MEDICAL CENTER,P.C.
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PEDIATRIC ALLERGY NEW PATIENT QUESTIONNAIRE

Name:
Age:
Date of Appointment:

INSTRUCTIONS: Please complete the following questionnaire as it is pertinent to the individual being evaluated. Completion of this form will assist us in evaluating and treating your child's allergy problem. Please bring the completed form with you to your appointment. Thank you.

Briefly describe the main reason for your visit and what you hope to accomplish.

Has your child ever had any of the following problems? Please check *all* items either Y, N or unsure

Condition	Y	N	Unsure	Age at Onset	Comments
Asthma (Wheezing)					
Other Breathing problems (cough, shortness of breath, frequent "chest colds")					
Sinus infections					
Nasal Polyps					
Hay fever (runny/stuffy/itchy nose)					
Hives or swelling					
Eczema					
*Reactions to Foods (please list below)					
Reactions to Drugs (please list)					
Reactions to Insect Stings					
Additional Comments:					

***Food Allergies:** List any foods to which your child has had an adverse reaction. If none leave blank.

Food	Age at time of reaction	Symptoms (i.e. eczema, hives, swelling, asthma)

Has your child ever had any of the following symptoms?					
Symptoms	**Y/N**	**How many days in the last month**	**Severity** mild, moderate, severe	**Worst Season** Spring, Summer, Fall, Winter	**Comments**
Runny or stuffy nose					
Itchy nose					
Sneezing					
Eyes: itching, watery					
Wheezing					
Coughing					
Wheezing or cough with exercise or play					
Noisy breathing					
Turning blue due to shortness of breath					
Chest tightness					
Night time awakenings due to shortness of breath or cough					
Skin problems					
Snoring					

Exacerbating Factors (Triggers)					
Please check each symptom box that that applies with exposure to the following:	**Symptom**				
	Asthma	**Nose/Sinus/Eyes**	**Eczema**	**Hives**	**Comments**
Animals (please name)					
Pollens/molds/mildews					
Respiratory infections, “Colds”					
Exercise					
Cold Air					
Foods					
Dust					
Air Pollution					
Fumes/Odors/Scents					
Car/Truck Exhaust					
Weather Changes					
Aspirin/Aspirin like drugs (i.e. ibuprofen, naproxen)					
Emotions/Stress					
Hormone changes/ menstruation					
Medications *(please name)*					
Work- related *(please name)*					
Other:					

Previous Allergy Evaluation and Therapy ***Please bring copies of results if possible**			
Allergy Skin Tests? Yes No	Dates:		
Allergy RAST Testing? Yes No	Dates:		
Allergy Injections? Yes No	Dates:	Start:	End:
Chest X-ray or CT scan? Yes No	Dates:		
Sinus X-ray or CT scan? Yes No	Dates:		
Have you ever needed sinus surgery? Yes No	Dates:		
Other:			

Medications: Please list any medications that your child is currently taking for allergies (including inhalers, creams, over the counter medications or herbal medicines) and any medications for other reasons.					
Current Allergy Medications			**Other Medications**		
Name	Dose	Times per Day	Name	Dose	Times per Day
Please list any Allergy Medications tried in the past.					
Has your child ever needed to take Oral Steroids for an allergic condition? (for example Orapred)					

Birth History
Place of Birth: (city/state)
Length of Pregnancy:
Type of Delivery:
Complications:
Developmental concerns:

Diet History
Breast fed? If so until what age.
Type of formula used (please indicate if soy, cow's milk , rice based, elemental):
Age at which solids were introduced:
Are any foods currently avoided? (please name)

Past Medical History: Please list any other illnesses or chronic medical conditions your child has had.	
Please list any other illnesses or chronic medical conditions your child has had:	
Please list all hospitalizations/surgeries: Please give reason and date.	
Immunizations:	
Are they up to date?	
Influenza vaccine? Date: of last injection:	

Family History			
Please list family members with any of the following: (siblings, parents, aunts, uncles, grandparents)			
Asthma		Emphysema	
Hay fever		Autoimmune diseases	
Eczema		Cancer	
Food Allergies		Heart Disease	
Hives		Diabetes	
Cystic Fibrosis		Glaucoma	
Recurrent infections		Other	

Social History
Child's primary caretaker(s):
Caretaker(s) occupation(s):
Who lives at home?
Does your child attend day care or school?
Are there any smokers at home or anywhere else your child spends time?
How many days of school has your child missed as a result of his/her illness in the past year?
What activities or sports does your child engage in?

Environmental History		
Residence: Please list your current/past residences (city, state) with the current address first		
City/Town & State	# of Years	Effect on Symptoms/Exposures

Please check all that apply regarding your current residence:			
	Smokers?		Wall-to-wall carpet?
	Pets/Birds? (what?)		Hard wood/tile floors?
	Swamp (evaporative) Cooler?		Air purification system?
	Air conditioning?		Pillow and mattress encasings?
	Humidifier?		Leaking roof or basement?
	Heating? (type: forced air, electric, water)		Mold or Mildew?
	Fireplace? (type: gas or wood burning)		Located near a busy road?
	Wood burning stove?		Other: