BOULDER MEDICAL CENTER, P.C.

Dear Patient,

We are pleased that you have chosen our clinic for your medical needs. Here are a few suggestions to make your visit with us a pleasant experience.

Please arrive 15 minutes prior to your scheduled appointment; this will give you ample time to check in at the front desk in our lobby and also, our department on the second floor.

If you have arranged for outside records to be faxed or mailed to us we would suggest you call our office a few days prior to your appointment to make sure we have received them. If we have not received your records prior to your appointment, you may be asked to reschedule.

Due to the length of an allergy consultation/work-up, there is a 48 hour cancellation policy. To avoid paying a no-show penalty please be sure to cancel your appointment 48 hours prior to your visit. To cancel your appointment, please call (303) 440-3083.

We look forward to meeting you.

Thank you,

Karen Andrews, MD
Katherine McCormack, MD
Madeline Hoglund, NP

2750 Broadway
Boulder, CO 80304

80 Health Park Dr, Suite 100
Louisville, CO 80027

Patient Name________________________ History Number _______________ DOB ______________

A-12

BLACK INK ONLY

BOULDER MEDICAL CENTER, P.C.
KAREN ANDREWS, M.D
KATHERINE MCCORMACK, M.D.
MADELINE HOGLUND, NP
TEL: (303) 440-3083 FAX 303-440-3100

Please fill out this form <u>prior</u> to your appointment

PEDIATRIC ALLERGY NEW PATIENT QUESTIONNAIRE

PATIENT'S PREFERRED NAME:	**PARENT'S NAMES:**
PRIMARY CARE PROVIDER:	**REFERRING PROVIDER:**

VERY IMPORTANT: 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. Failure to do so may result in asking you to reschedule this 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)

Patient Name______________________ History Number__________________

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:

Patient Name______________________ History Number___________________

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:	

Patient Name______________________ History Number___________________

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: