The information you provide in this questionnaire will assist the doctor who is seeing you in clinic. Please answer these questions to the best of your ability. **All questions apply to the patient. If the patient is a child, please fill out this form on his or her behalf.**

PATIENT INFORMATION

Name of patient: ______________________
Name of parent(s): ______________________
Date of birth: __________ Age __________
Address: ______________________
City, State, Zip ______________________
Phone __________ Work __________ Cell __________
E-mail ______________________
Primary Care physician ______________________
Referring physician ______________________

Reason for referral:

☐ Allergies/Hay fever ☐ Asthma or chronic cough
☐ Food allergy ☐ Eczema or other skin rash
☐ Drug reaction ☐ Insect sting reaction
☐ Hives or swelling ☐ Intestinal problems
☐ Eye problems ☐ Headaches
☐ Recurrent infections
☐ Other: ______________________

Describe in your own words the problem(s) that you (the child) are having:

____
____

Have you been evaluated by an allergist before? ☐Yes ☐No By whom? __________ When? __________
Have you had allergy skin testing performed? ☐Yes ☐No By whom? __________ When? __________
Test results? __________
Have you ever had allergy injections? ☐Yes ☐No Were they helpful? __________
Have you had a problem with the injections? ☐Yes ☐No If they were stopped, why were they stopped? __________
Have you been evaluated by an Ear, Nose, and Throat doctor? ☐Yes ☐No
Have you ever had sinus or nose surgery? ☐Yes ☐No When? __________

PAST MEDICAL HISTORY

Birth history: Born ☐Full Term ☐Premature Delivery: ☐Vaginal ☐C-section
Birth Weight ____lbs ____oz Problems at birth? __________

Please list any of the child's medical problems:

____

Has your child ever been hospitalized? ☐Yes ☐No If yes, list the dates and reasons below

Date	Reason for hospitalization
________	______________________
________	______________________

Has your child ever had surgery? ☐Yes ☐No If yes, list the dates and procedures below

Date	Procedure
________	______________________
________	______________________

List any allergies to medications ______________________ What was the reaction? __________

Are the child's **Immunizations** up to date? ☐Yes ☐No

medications, birth control pills, iron, aspirin, nasal sprays, and inhalers).

Medications	How much?	How often?	Medications	How much?	How often?

FAMILY HISTORY

Check the appropriate boxes to indicate allergic problems in family members of the child:

	Father	Mother	Sisters	Brothers	Children
Asthma					
Allergies/HayFever					
Eczema					
Food Allergy					

Is there a history of cystic fibrosis or immune deficiency in the family? ☐Yes ☐ No Who?______________
Do any other diseases run in the family? ☐Yes ☐No If yes, what?______________

ENVIRONMENTAL HISTORY

What kind of place do you live in? ☐House ☐Apartment ☐Mobile home ☐Other______________
What is the age of your home? ______________
Is there carpeting in the bedrooms/sleeping areas? ☐Yes ☐ No
Are there allergy (dust mite) covers on the bedding? ☐Yes ☐ No
Does it have a basement? ☐Yes ☐ No Damp or musty? ☐Yes ☐ No
Do you have pets? ☐Yes ☐ No If yes, what? ☐Dog ☐Cat ☐Bird ☐Other______________
Where do they stay? ☐Indoors ☐Outdoors Do any pets sleep in your bedroom? ☐Yes ☐ No
Do you use anything special to control dust mites in the home? ☐Yes ☐ No
Does anyone in the home smoke? ☐Yes ☐No
If patient is a child, do they attend day care/school? ☐Yes ☐No Since what age?______________

REVIEW OF SYSTEMS (check yes or no for ongoing or recurring symptoms)

Symptom/problem	Y	N	Symptom/problem	Y	N	Symptom/problem	Y	N
General			**Lungs**			**Skin**		
Fever			Wheezing			Recurring boils		
Weight changes			Recurring cough			Rashes		
Appetite changes			Symptoms with exercise			Hives		
Headache						Swelling		
Eyes			**Stomach**			**Hematologic/Lymphatic**		
Vision problems			Vomiting			Excessive bruising/bleeding		
Drainage			Diarrhea			Swollen glands		
Redness			Constipation			**Neurologic**		
Ear/Nose/Throat			Abdominal pain			Seizures		
Ear infection			Heartburn/reflux			Changes in school		
Throat infections/tonsillitis						Developmental problems		
Mouth ulcers			**Joints**			**Other**		
Thrush			Swelling of the joints					
Heart			Joint pain					
Murmurs			Muscle weakness					
Rhythm abnormalities								