



ALLERGY/IMMUNOLOGY NEW PATIENT QUESTIONNAIRE

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| | |
|---------------------------------|--------------------------|
| Name: | Date of Birth: |
| Pharmacy Name: | Pharmacy Address: |
| Specialty Pharmacy Name: | |

I want to know:

My questions are:

I don't want to leave without this (asthma or epinephrine action plan, prescription, etc):

REVIEW OF SYSTEMS

Has your child been experiencing or diagnosed with any of the following?
Please check any that apply

| | | |
|---|--|--|
| General <input type="checkbox"/> Feeling tired <input type="checkbox"/> Fevers <input type="checkbox"/> Chills or night sweats <input type="checkbox"/> Poor weight gain <input type="checkbox"/> Changes in appetite | Lungs <input type="checkbox"/> Cough <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Wheezing | Endocrine <input type="checkbox"/> Excessive thirst <input type="checkbox"/> Hot or cold intolerance <input type="checkbox"/> Thyroid disorders <input type="checkbox"/> Diabetes <input type="checkbox"/> Delayed puberty |
| Eyes <input type="checkbox"/> Red or itchy eyes <input type="checkbox"/> Blurred or altered vision <input type="checkbox"/> Sensitivity to light | Heart <input type="checkbox"/> Heart murmur <input type="checkbox"/> Heart palpitations/irregular heartbeat <input type="checkbox"/> Heart defects | Skin <input type="checkbox"/> Rash <input type="checkbox"/> Birth marks or large moles |
| Ear/Nose/Throat <input type="checkbox"/> Nasal congestion/snoring <input type="checkbox"/> Post nasal drip/nasal discharge <input type="checkbox"/> Ear or throat pain <input type="checkbox"/> Nose bleeds <input type="checkbox"/> Nasal polyps <input type="checkbox"/> Loss of smell | Gastrointestinal <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> Abdominal pain <input type="checkbox"/> Nausea/Vomiting <input type="checkbox"/> Acid reflux/heartburn <input type="checkbox"/> Blood in stool <input type="checkbox"/> Enlarged liver or spleen | Bones/joints <input type="checkbox"/> Muscle pain <input type="checkbox"/> Joint pain/swelling |
| Urinary <input type="checkbox"/> Pain with urination <input type="checkbox"/> Increased frequency of urination <input type="checkbox"/> Urine infections | Blood <input type="checkbox"/> Easy bruising or bleeding <input type="checkbox"/> Swollen glands <input type="checkbox"/> Anemia <input type="checkbox"/> Low white blood cell/platelet counts | Neurologic <input type="checkbox"/> Headaches <input type="checkbox"/> Dizziness or lightheadedness <input type="checkbox"/> Weakness/numbness/tingling <input type="checkbox"/> Seizures |
| | | Psychiatric <input type="checkbox"/> Hyperactivity disorder <input type="checkbox"/> Depression or anxiety <input type="checkbox"/> Sleep disturbances |

BOSTON CHILDREN'S HOSPITAL, 300 LONGWOOD AVE., BOSTON, MA 02115

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LABEL OR PRINT

NAME

CH MRN

Has your child been diagnosed or suspected to have any of the following:

Asthma? Yes No
If yes: Has your child been hospitalized? Yes No
 Has symptoms with exercise/activity? Yes No
 Taken oral steroids? Yes No If yes, how often? _____

Eczema? Yes No
If yes: What skin moisturizers are used? _____
 How often does your child bathe? _____
 Difficulty sleeping due to itching? Yes No
 Has your child had skin infections? Yes No

Nasal/Eye Allergies? Yes No
If yes: What symptoms? Sneezing Congestion Post-nasal drip Runny nose Red itchy eyes
 Other symptoms: _____
 What triggers your child's symptoms? _____
 What seasons are worse? Spring Summer Fall Winter Always bad

Increased frequency/severity of infections? Yes No
If yes: What type of infections? Ear infections Sinus infections Pneumonias Bronchitis Other
 How many courses of antibiotics has your child taken in the past 12 months? _____

Food allergies? Yes No
If yes, please list foods restricted: _____

Has your child had any other medical problems or diagnoses? _____

Has your child been hospitalized or had any surgeries? If yes, please describe: _____

List any medication allergies: _____

Are your child's immunizations up to date? Yes No ; Did your child receive the influenza vaccine this year? Yes No

FAMILY HISTORY: Please indicate if the patient's parents or siblings have had any of the following conditions:

| | Asthma | Nasal/Eye Allergy | Eczema | Food Allergy | Drug Allergy | Immune Deficiency |
|------------------------------|--------|-------------------|--------|--------------|--------------|-------------------|
| Biological Mother | | | | | | |
| Biological Father | | | | | | |
| Child's Brothers and Sisters | | | | | | |

ENVIRONMENTAL HISTORY:

Does your child live in: An apartment A house A multifamily house/condo Other: _____

Multiple home settings: _____

Do you have a basement? Yes No **If Yes:** Is it Finished Dry Damp Has flooded

Climate control: Hot water heat Steam heat Forced hot air Wood stove Space heater

Central AC Window A/C Air filters Air cleaner/purifier

Humidifier Dehumidifier Other: _____

Does your home have? Mold or mildew Damp or musty smell Water stains Mice Cockroaches None

Flooring: Hardwood Tile/linoleum Wall to wall carpeting Area rugs Other: _____

Exposure to pets? No Yes (If yes, please describe): _____

Do you or any of your child's caretakers smoke? No Yes

Does your child's bedroom have? Stuffed animals Rugs Carpeting Blinds Curtains

Air conditioning Humidifier Feather pillow Down comforter

Air cleaner/purifier Allergy-proof mattress or pillow covers

School, work, or day care environment (please describe): _____

Patient/Patient Representative Signature

Name (printed):

Relationship to patient
or Patient

Time

Date