Allergy and Asthma Specialist of Northeast Louisiana™

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Pediatric New Patient Information

Child's Name:____ Date of Birth: ________________

Parent's Names:____

Child's Regular Pediatrician or Doctor:____

Phone # (_______)________________________ Pharmacy:____

Would you like the office note from today's visit sent to your primary care doctor? ☐ Yes ☐ No

CHECK APPROPRIATE BOX AND FILL IN THE BOX AND FILL IN THE BLANK SPACES

PAST HISTORY:

Birth Weight:___________________Complications:____________________________ Feeding History: ☐ Breast

How Long? ________ ☐ Formula, What Kind?____________ Multiple Formula changes? ☐Yes☐ No

PREVIOUS ILLNESSES: (Yes or No; If yes, how often?)

Ear Infections:____

"Step Throat":____No. Per Year ____________

Colds:____

Pneumonia:____

Sinusitis:____ Sinus X-rays: ☐ Yes ☐ No Date:_____________

Skin Rashes (other than diaper rash or "heat rash"):____

____

List Know Allergies (include medication):____

____

____

Hospitalizations: Where, When, for What Reasons?____

____

____

Immunizations: Up to date for age: ☐ Yes ☐ No

Does your child now have, or has he/she had, problems with certain foods, i.e., rashes, vomiting, diarrhea?___________

____

____

ALLERGY HISTORY:

Briefly state your child's problem:

Describe a typical attack:

Date (or age) of onset:

What do you think may bring on an attack? (Check those appropriate)

Foods	☐	Exertion(Exercise)	☐	Dampness or Rain	☐
Temperature Changes	☐	Infection	☐	Drugs	☐
Odors, Cosmetics	☐	Dust	☐	Animals	☐
Other	☐	Pollen	☐		

When are the symptoms more severe? (Check those appropriate)

Fall	☐	Night	☐	School	☐
Winter	☐	Day	☐	Other Places	☐
Spring	☐	Home (Indoors)	☐	______________________________	
Summer	☐	Home (Outdoors)	☐	______________________________	

How many school days has your child missed in the past year? ____

Has your child been evaluated by an allergist in the past? ☐ Yes ☐ No

If so, name of allergist:____

Skin Test: ☐ Yes ☐ No Dates:______________ __ Allergy Injections: ☐ Yes ☐ No Dates: _________________

List any medications your child has taken or is now taking:

1) Antihistamines (Rynatan, Dimetapp, Bromfed, Benadryl, Seldane, Hismanal, Atarax): _____________________________

____

2) Decongestants (Sudafed, Entex):____

____

3) Antibiotics:____

4) Wheezing Medicine (Ventolin, Proventil, Alupent, Slobid, TheoDur):____

____

5) Steroids (Prednisone, Decadron):____

6) Sprays, mists, nose drops:____

7) Other:____

ENVIRONMENT:

- Do you reside in a ☐ single home or ☐ apartment? How old is the residence? ___________________________
- Heating: ☐ forced air gas ☐ electric heat pump ☐ space heaters ☐ wood-burning heater ☐ fireplace
- Air conditioning: ☐ central ☐ window units
- Fans: ☐ ceiling ☐ window
- Humidifier/Vaporizer: ☐ room ☐ central Dehumidifier: ☐ room ☐ central
- Special allergy air filter: ☐ room ☐ central ☐ electrostatic ☐ HEPA
- Your child's bedroom:

  Carpeting: ☐ Yes ☐ No

  Type: ☐ Shag ☐ Low Pile ☐ Medium Pile ☐ Plush ☐ Indoor/outdoor

  Type of Mattress: ☐ Regular ☐ Waterbed How Old?___________ Plastic covered ? ☐ Yes ☐ No

  Type of Pillows: ☐ Feather ☐ Non-feather How Old?__________ Plastic covered? ☐ Yes ☐ No

  ☐ Blankets ☐ Quilts ☐ Comforter ☐ Bedspread ☐ Washable ☐ Non-washable

  Curtains, drapes, or mini-blinds in bedroom? ☐ Yes ☐ No

  Number of stuffed animals in the room or bed? ☐ Many ☐ Few ☐ None
- Do you have any pets? ☐ Yes ☐ No What kinds? ____
- Where do your pets live? ☐ Indoors ☐ Outdoors Access to Bedroom: ☐ Yes ☐ No

  How often does your child come in contact with these animals? ____
- Is there anyone living in your home that smokes? If so, who?____

  ____
- Is mold or mildew (smell of dampness a problem in or around the home?____________________________________
- Does your child attend a day care center, a nursery school? ☐ Yes ☐ No If so, how many days per week:_____

  Hours per day _____________ Approximately how many children are in your child's class?_____________________

FAMILY HISTORY:

	Mother	Father	Brother / Sister	Other
Asthma (now)				
Childhood Asthma				
Hay Fever				
Eczema				
Food Allergies				
Drug Allergies				
Other				

Do other members of the immediate family have any significant health problems?_________________________________

____

____

Has your child had any other significant health problems?____

____

____

____

REVIEW OF SYSTEMS

Check the box if you have recently experienced or received medical treatment for any of the following:

	YES	NO
Constitutional		
Fever	☐	☐
Chills	☐	☐
Night sweats	☐	☐
Weight loss	☐	☐
Weight gain	☐	☐
Fatique	☐	☐
Poor appetite	☐	☐
Inability to sleep	☐	☐
Eyes		
Ocular itching	☐	☐
Worsening eyesight	☐	☐

	YES	NO
Cataracts	☐	☐
Glaucoma	☐	☐
Eye irritation/inflammation	☐	☐

Ears/Nose/Throat

	YES	NO
Ear pain	☐	☐
Ear drainage	☐	☐
Hearing loss	☐	☐
Noise/ringing in ears	☐	☐
Nasal blockage	☐	☐
Nasal drainage	☐	☐
Sneezing	☐	☐
Bloody nose	☐	☐
Sinusitis	☐	☐
Tooth pain	☐	☐
Sore throat	☐	☐
Hoarseness	☐	☐

Cardiovascular

	YES	NO
Pain/tightness in chest	☐	☐
Heart murmurs	☐	☐
Swelling of feet	☐	☐
Palpitations or rapid heart beat	☐	☐
Pain or aching in legs with exercise	☐	☐
High blood pressure	☐	☐

Respiratory

	YES	NO
Wheezing	☐	☐
Persistent cough	☐	☐
Cough up sputum (phlegm) Rarely or Often **(circle one)**	☐	☐
Cough up blood	☐	☐
Pneumonia	☐	☐
Pleurisy (painful to breath)	☐	☐
Blood clot to lung	☐	☐
Shortness of breath: At rest/ With exercise **(circle one)**	☐	☐

Gastrointestinal

	YES	NO
Heartburn or indigestion	☐	☐
Difficulty swallowing		
Nausea and/or vomiting	☐	☐
Stomach pain	☐	☐
Stomach ulcer	☐	☐
Vomiting blood	☐	☐
Recent change in bowel habits	☐	☐
Diarrhea	☐	☐
Constipation	☐	☐
Black (tarry) or bloody stools	☐	☐
Hemorrhoids	☐	☐
Jaundice or hepatitis	☐	☐

Genitourinary

	YES	NO
Frequent urination	☐	☐
Discomfort on urination	☐	☐
Difficulty starting urination	☐	☐
Protein or blood in urine	☐	☐
Urinary or kidney infection	☐	☐
Kidney stones	☐	☐
Dribbling with cough, Sneezing or laughing	☐	☐
Abnormal discharge	☐	☐

Musculoskeletal

	YES	NO
Joint pain	☐	☐
Joint swelling	☐	☐
Arthritis	☐	☐
Muscle aches or weakness	☐	☐
Ulcers (open sores) of legs or feet	☐	☐

Integumentary

	YES	NO
Rash	☐	☐

Lumps or pain in breasts	☐	☐
Discharge or bleeding nipples	☐	☐
Edema (swelling of body)	☐	☐
Unusual hair loss	☐	☐

Neurological

Headaches	☐	☐
Migraine headache	☐	☐
Dizzy spells	☐	☐
Fainting/falling out	☐	☐
Epilepsy/seizers	☐	☐
Loss of memory	☐	☐
Numbness or burning In feet	☐	☐
Stroke/paralysis	☐	☐
Difficulty with speech	☐	☐

Psychiatric

Inability to sleep	☐	☐
Significant sleep disturbances	☐	☐
Significant mood disturbances	☐	☐
Depression	☐	☐

Endocrine

Increased thirst	☐	☐
Increased urination	☐	☐
Intolerance of heat	☐	☐
Intolerance of cold	☐	☐
Diabetes Mellitus	☐	☐
Goiter/Thyroids	☐	☐

Heme/Lymphatic

Anemia or low blood flow	☐	☐
Bruise or bleed easily	☐	☐
Swollen glands	☐	☐

Allergic/immunologic

Frequent Hives	☐	☐
Frequent swelling	☐	☐
Recurrent sinus infections	☐	☐
Recurrent ear infections	☐	☐
Recurrent pneumonia	☐	☐

***Other recent medical problems?** ☐ Yes ☐ No

Please describe:____

____

____

Please list current medications including strength and dosage:

____

____

____

____

____

____ ________________
Parent/ Guardian Signature Date

(Do not write below this line)

I have reviewed the history with the patient and agree with the information provided in this form.

____ _____________________
Signature of Physician Date