Allergy, Asthma, and Immunology
Children's Hospital of The King's Daughters

Pharmacy & location: __________________________
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Allergy/Asthma Questionnaire

Please take a few moments to tell us about your child's medical history prior to their initial visit with our clinic. **Please bring this form to your child's first appointment.**

Who is the primary caregiver? ☐ Mom ☐ Dad ☐ Grandparent ☐ Foster Parent ☐ Other:________

Please describe the reason for your visit? ____
____

Are the patient's shots up to date? ☐ Yes ☐ No
Is the patient's flu immunization up to date? ☐ Yes ☐ No
Within the last 30 days, has your child been exposed to: ☐ Measles ☐ Mumps ☐ Chicken pox ☐ Tuberculosis ☐ None

Known **allergies** and their reactions:
____
____

Please list current **medications**:
____
____
____

Has the patient ever had any **serious injuries or illnesses**? ☐ Yes ☐ No
If yes, please explain: ____
____

Please check any **current symptoms**: ☐ None

☐ Recurrent Fever
☐ Weight Changes
☐ Changes to Appetite
☐Changes to activity level
☐ Ear infections
☐ Sore throat
☐ Post nasal drip
☐ Itchy eyes
☐ Eye swelling

☐Shortness of breath with exercise
☐ Cough
☐ Wheeze
☐ Shortness of breath at rest
☐ Chest tightness
☐ Vomiting
☐ Diarrhea

☐ Seizures

☐ Behavioral Diagnosis: ______________________
☐ Broken bones
☐ Swollen joints
☐ Weak muscles
☐ Chicken pox
☐ Current infection/on antibiotics: _____________
☐ Stuffy nose
☐ Runny nose
☐ Sneezing

☐ Stomach pain
☐ Trouble swallowing
☐ Itchy nose
☐ Headaches
☐ Heart murmurs
☐ Irregular heartbeat
☐ Constipation
☐ Anemia
☐ Heartburn
☐ Blood in urine
☐ Painful urination
☐ Urinary tract infection
☐ Family related blood disorder: ______________________

Known medical conditions:
☐ Asthma
☐ Allergies
☐ Pneumonia
☐ Eczema
☐ Hives
☐ Bee Sting Allergy
☐ Food Allergy: ________________________
☐ Drug Allergy: ________________________
☐ Recurrent Infection: _________________

Please check those items which **trigger** your child's allergy or asthma symptoms:

	Yes	No		Yes	No
Dust			Pollens		
Cold Air			Cigarette Smoke		
Exercise			Strong odors		
Viral Infection			Cats		
Ear or Sinus Infections			Dogs		
Weather Changes			Other		

Home Environment:

Cockroaches ☐ Yes ☐ No
Mold ☐ Yes ☐ No
HEPA Filter ☐ Yes ☐ No
Wood Burning Stove ☐ Yes ☐ No

A/C ☐ Central ☐ Room ☐ None
Stuffed Animals on the bed ☐ Yes ☐ No
Allergy Covers on the bed ☐ Yes ☐ No

Please identify **family medical history**.

Illness	Mother	Father	Sister	Brother
Asthma				
Eczema				
Food allergy				
Allergies (pollen, animals, etc.)				
Sinus Disease				

Social History:
Sports, hobbies, activities: ____

Who lives in the home? ____
Exposure to smoke: ☐ None ☐Exposed inside the home ☐Patient smokes ☐Caregiver smokes outside the home

Is the patient around pets or animals? ☐Yes ☐No What kind of animals? _________________
Where does the child live? ☐Single family home ☐Apartment ☐Trailer ☐Other: __________

School Information:
Name of school: ________________________________ Current grade: _____________
How many days of school has the patient missed this school year due to asthma? _______

Birth History During Pregnancy:
Any illness? ☐Yes ☐No
If yes, please explain? ___________________________
Was the pregnancy full term? ☐ Yes ☐ No
If no, number of weeks or months __________________________________
Any complications during the pregnancy or delivery? ☐ Yes ☐No
If yes, please explain: ____

Nutrition:
Was the patient breast fed: ☐Yes ☐No If no, what formula? ___________________________