ALLERGY ASTHMA IMMUNOLOGY OF ROCHESTER PC

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PEDIATRIC QUESTIONNAIRE

This form is to be filled out by the parent. Please bring it with you when you come for your appointment.

Patient's Name: _____ Age: ____ Birthdate: __/__/__

Address: _____ Zip Code: _____

Telephone: ( ) _____ School and Grade: _____

Father's Name: _____ Place of Business: _____

Mother's Name: _____ Place of Business: _____

Referring Physician: _____

Address: _____

Other Children: _____

(List with Age): _____

Family History:

	Asthma	Hay Fever	Eczema	Hives	Food Allergy	Other
Relation to patient						

Other include: Tuberculosis, Cystic Fibrosis, Frequent Infections, Sinus Condition, Emphysema, Boils, Other.

Past History:

1. Birth Weight: _____
2. Complications At Or After Birth: _____
3. Type of Feeding: Breast _____ Bottle (kind of milk): _____
4. Was it necessary to change formula? Yes ____ No ____
5. Solid Food (age started): Cereal _____ Egg _____ Meat _____ Fruit ____

	Age at Start	Age Stopped	Cause
Diarrhea			
Spitting Up			
Eczema			
Colic			

6. Childhood Illnesses: Measles, Mumps, Chickenpox, German Measles, Whooping Cough, Scarlet Fever. (Circle)

7. Other Illnesses: _____

8. Operations (Date): _____

9. Foods Causing Reactions: _____

10. Drugs Causing Reactions: _____

11. Immunizations (Dates): Circle if became sick from injections:

    a. Diphtheria, Whooping Cough (Pertussis), Tetanus: _____

    b. Polio: _____

    c. Measles: _____

    d. German Measles: _____

    e. Mumps: _____

    f. Influenza: _____

    g. Has patient ever received horse serum (tetanus) (antitoxin): _____

    h. Smallpox vaccination: _____ j. Influenza: _____

    i. Tuberculosis test: _____ k. Pneumovax: _____

12. Medications used to treat symptoms (or other conditions):

Drugs (List):	Symptom Drug Used For	Does Drug Help?

13. Does patient use?: Aspirin _____ Tylenol _____ Both _____

14. Type of House: _____ Age of House _____

    How long have you lived in house?: _____

15. Heating system: _____ Is there a humidifier or air filter on furance?: Yes ___ No ___. Is home dry in winter?: Yes ___ No ___.

16. Wood-burning Stove: Yes ___ No ___.

17. Bedroom: a. Does child sleep with special toy or blanket? Yes _____ No _____

b. Own or shared _____ f. Type of pillow _____

c. Type of mattress _____ g. Type of rug _____

d. Type of curtains _____ h. Type of bedspread _____

e. Is room dry _____ i. Type of pad under rug _____

18. Pets: _____ Where does pet sleep _____

How long in house: _____

19. Basement: a. Finished _____ Describe: _____

b. Damp _____ Describe: _____

c. Musty _____ Describe: _____

20. Do you live on or near:

a. Farm _____ Describe: _____

b. Barn _____ Describe: _____

c. Factory _____ Describe: _____

21. Frequent colds? _____ Number per year: _____

22. Frequent sore throats: _____ Number per year: _____

23. Frequent ear infections: _____ Hearing loss: _____

24. Odors causing problems (paint, gas, perfume): _____

25. Symptoms from insect sting: _____

26. History of poison ivy: _____

27. Number of days absent from school: This Year _____ Last Year _____

Reason: _____

28. Where have you traveled in the past 18 months?: _____

29. Does your child have any other medical conditions for which you have consulted a specialist? Yes _____ No _____

30. Recent Chest X-ray? Yes _____ No _____. Date _____ Place _____

31. Who at home smokes tobacco?: _____

32. Briefly, describe or list your child's present problems (symptoms, age of onset, frequency), and list questions and/or concerns. These will be discussed.

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