Rady Children's Hospital San Diego

Specialty Clinics
Rady Children's Hospital
3020 Children's Way
San Diego, CA. 92123

DTF748

PATIENT INORMATION
Name: _____
MR#: _____ Finance: _____
DOB: _____
MD: _____

Patient Allergy History Questionnaire

Child's Name _____ Date of Birth _____/____/_____

What is the main reason your child is being seen in the Allergy Clinic?_____

_____

1. COUGH OR POSSIBLE ASTHMA (if none go to section 2)

Check any of the following that are problems for your child:

☐ Cough ☐ Wheeze ☐ Shortness of breath ☐ Chest tightness

How old was your child when he/she first began having these chest symptoms? _____

Are there a certain times of year when these asthma/chest symptoms are worse? ☐Yes ☐No
If yes, which months? _____

Check any of the following that make the asthma/chest symptoms worse: ☐ Animals, which animals: _____

☐ Dust ☐ Grass ☐ Smoke ☐ Fumes ☐ Cold air ☐ Windy weather

☐ Respiratory infections ("colds") ☐ Exercise ☐ Other (list) _____

Has your child ever had to stay overnight in the hospital because of asthma/chest symptoms? ☐Yes ☐No
If yes, approximately how many times: _____ Date of last hospital stay:_____ How many ICU stays_____

Has your child ever had to go to the ED or urgent care because of asthma/chest symptoms? ☐Yes ☐No
If yes, how many times in the past 12 months _____

Has your child ever had pneumonia? ☐Yes ☐No If yes, How many episodes? _____
How many school days has your child missed this school year due to these symptoms? _____
How many days of work have you missed due to your child's symptoms? _____
How many nights has your child awoken from sleep because of wheezing of cough in the last 2 weeks? _____
How many days or nights in the past 2 weeks has your child needed to use an inhaler or nebulizer to treat wheezing or cough? _____

Does your child have a peak flow meter: ☐Yes ☐No If Yes, Best Peak Flow: _____

2. NOSE OR EYE SYMPTOMS (If none go to section 3)

Check any of the following that are problems for your child: ☐Runny nose ☐Stuffy nose ☐Itchy nose ☐Sneezing fits

☐Watery eyes ☐Red eyes ☐Itchy eyes ☐Itchy ears ☐Itchy throat ☐Post nasal drip ☐Throat clearing

How old was your child when he/she first began having these nose/eye symptoms? _____

Which seasons are these nose/eye symptoms occur? ☐ Spring (March to May) ☐Summer (June to August)

☐ Fall (September to November) ☐ Winter (December to February) ☐ All the time

Check any of the following that make the nose/eye symptoms worse: ☐Cats ☐ Dogs ☐ Dust

☐ Grass ☐ Smoke ☐ Fumes ☐ Cold air ☐ Other: _____

Has your child ever had allergy skin testing before? ☐ No ☐ Yes

If yes, check those tests were positive: ☐ Dust Mite ☐ Pollen ☐ Mold ☐ Animal Hair ☐ Foods

Has your child ever been on allergy shots before? ☐Yes ☐No

3. ECZEMA (CHRONIC DRY ITCHY SKIN)(if none go to section 4)

How old was your child when he/she first began having eczema? _____

Check Body Parts with eczema: ☐Face ☐Scalp ☐Arms ☐Legs ☐Chest ☐Abdomen ☐Back

Are there any foods that seem to worsen the eczema? ☐Yes ☐No If yes, which foods? _____

_____

4. FOOD REACTIONS (if none go to section 5) - List foods to which you suspect your child is allergic and check reaction type

Food	Rash/hives/ eczema	Vomiting/ diarrhea	Facial Swelling	Difficulty breathing	Shock	Other

How long after eating the food did the reaction occur (check one): ☐within 2 hours ☐2-24 hours ☐greater than 24 hours

Did your child go to the emergency room or acute care for the reaction? ☐Yes ☐No

Did your child require oral medicine or a shot to treat the reaction? ☐Yes ☐No

How old was your child when he/she had the first suspected reaction to the food? _____

When was your child's most recent reaction to the food? _____

Has your child ever had skin tests or blood tests for food allergy? ☐Yes ☐No

If yes, which tests were positive? _____

Medications (please check all your child has used or tried):

Inhalers: ☐Flovent ☐Qvar ☐Pulmicort ☐Advair ☐Serevent ☐Foradil
☐Albuterol ☐Asmacort ☐Asmonex ☐Other:_____

Nasal Sprays: ☐Nasonex ☐Rhinocort ☐Nasocort ☐Atrovent ☐Afrin ☐Neosynephrine

Antihistamines: ☐Allegra ☐Benadryl ☐Zyrtec ☐Atarax ☐Claritin ☐Clarinex

Skin preparations: ☐Hydrocortisone ☐Aclovate ☐Triamcinolone ☐Elocon ☐Elidel
☐Protopic ☐Cutivate ☐Other:_____

Nebulized Medications: ☐Albuterol ☐Xoponex ☐Pulmicort ☐Atrovent

List any bad reactions your child has had to any medication: _____

_____

List all medicines your child is currently taking for any reason (include over the counter, herbal, and homeopathic remedies)

_____ _____

_____ _____

_____ _____

ENVIRONMENT

Check any pets that you have: ☐Dogs ☐Cats ☐Hamster ☐Guinea Pig ☐Other:_____

Do any members of your household smoke: ☐Yes ☐No

About how old is your home? _____ years

Has there been any water damage or mold present in the home? ☐Yes ☐No

Where does your child sleep: ☐Own bed ☐with sib or parent ☐Other (such as sofa)

Has your child had a bad reaction (hives, wheezing, swelling, paleness, etc.) to: ☐bee sting ☐wasp sting ☐hornet sting ☐ant sting ☐latex (balloons, rubber, or elastic)

FAMILY HISTORY (Check all that apply) :

Relative	Asthma	Nasal allergy	Eczema	Food allergy	Hives
Mother					
Father					
Brother or sister					

List other diseases that run in the family: _____

Past History

List by date any hospitalizations for problems other than asthma: _____

_____

List any surgeries and dates: _____

List your child's birth weigh: _____ Was your child premature? ☐No ☐Yes

List any newborn problems: _____

Review of Systems (Where asked check yes or no)

Skin: Has your child had hives? ☐Yes ☐No If yes, how many days did the hives last? _____

HEENT: How many ear infections has your child had in the last year? _____

How many sinus infections has your child had in the last year?_____

Has your child had PE (ear) tubes placed? ☐Yes ☐No

Does your child have difficulty swallowing, pain with swallowing, or heartburn? ☐Yes ☐No

Heart: Has your child ever had a heart murmur or irregular heart beat? ☐Yes ☐No

Has your child ever fainted or passed out? ☐Yes ☐No

GI tract: Does your child have frequent loose stools? ☐Yes ☐No

Has your child had any liver problems, such as hepatitis? ☐Yes ☐No

Nervous system: Has your child had seizures? ☐Yes ☐No

List any learning problems your child has: _____

Kidneys: Does your child have any kidney problems? ☐Yes ☐No

To the best of my knowledge, the information provided here is correct:

_____ _____

Parent/Guardian Provider

Date ____/____/_____ Time:_____ Date ____/____/_____ Time:_____