PEDIATRIC ALLERGY DATA BASE AND HEALTH HISTORY

<u>Please fill in this form and send it to the office one week before the first visit in our office</u>. You may need to observe your child's symptoms for a few days in order to provide the best information. Try to be as accurate and complete as possible.

Patient's Information:

Name________________________________ Referred By:______________________________
Date of office visit__________ Sex _______ Age_____ Child's physician(s)__________________________
Date of Birth _____________ Next of Kin__________________________ Relationship_______________
Last school grade completed by patient_______ Social Security # ______________________________
Marital status of parents (circle): married separated divorced widowed

Father's Information:

Name:______________________________________ Social Security #_____________________________
Date of Birth: ________________ Home Phone: __________________ Work Phone: ____________________
Address: ____
Employer's Name: ____________________________ Occupation: _________________________________
Address____

Mother's Information:

Name:______________________________________ Social Security #_____________________________
Date of Birth: ________________ Home Phone: __________________ Work Phone: ____________________
Address: ____
Employer's Name: ____________________________ Occupation: _________________________________
Address____

Insurance Information:

Name of individual responsible for bill____

Primary Insurance Company: ______________________________ Ins Phone #: ____________________
Insurance Address: ____
Subscriber name: _______________________ Date of Birth: ____________ Relationship: _____________
Subscriber SSN#: _________________________ ID/Group Number: ______________________________

Secondary Insurance Company: ______________________________ Ins Phone #:
____
Insurance Address: ____
Subscriber name: _______________________ Date of Birth: ____________ Relationship: _____________
Subscriber SSN#: _________________________ ID/Group Number: ______________________________

Pharmacy Name and Phone ____

Problems (Give a brief summary of the patient's symptoms, duration of symptoms, aggravating and relieving factors, and patterns noted.)

Medications to which the patient is allergic and the symptoms produced. ______________________________

____

____

Current medications, names and dosages. (Include all medication and vitamins taken over the past month.)____

____

____

____

____

Did this child have any severe reactions to immunizations? Please list and describe. ____________________

____

Is this child current in his/her immunizations? ____________________

Please circle any problems noted with the mother during the pregnancy with this child:

High Blood Pressure   Diabetes   German Measles   Sugar, Protein, Albumin in the Urine

Venereal Disease   Drug or Alcohol Dependence   Cigarette Smoking

What medications did the mother take during this pregnancy? ______________________________

____

How long was this pregnancy?____________________ Was it a difficult delivery?____________________

Was more than one baby born?____________________ Was this a breech delivery?____________________

Was this a cesarean delivery?____________________ Was this a forceps delivery?____________________

How early did the mother start seeing the doctor?____

APGAR score ______________________________ Birth Weight ______________________________

Birth Defects ____

MATERNAL AND FAMILY HISTORY

How many children have you(mother) had?____________________

Which one is this child? (Birth order)____________________

Have you (mother) had any premature births or miscarriages? ____________________

Mother's age now__________ Height__________ Weight__________

Father's age now__________ Height__________ Weight__________

Names and ages of your other children____________________

Who lives in the home with this child?____________________

Where else does this child spend significant amounts of time? ____________________

FEEDING HISTORY

Did you breastfeed this child?__________ Did you have problems nursing this child?__________

If so, please describe.____________________

Were there any foods that you ate during the time that you were nursing this child that seemed to have an effect on him/her? Which foods were they and what effect did they cause?____________________

Did this child gain weight well in infancy?____________________

List brands of infant formula used. If there was any need to switch brands please list brand(s) and problem(s).

Have you noted any problems this child has had with foods?

FOOD	IN INFANCY	NOW	SYMPTOMS
Milk			
Wheat			
Eggs			
Corn			
Soybean			
Sugar			
Citrus			
Chocolate			
Food coloring			
Others			
Was this child colicky?			

Please circle any of the following that your child has had.

Chickenpox Rheumatic Fever Measles German Measles Mumps
Recurrent Ear Infections Recurrent Throat Infections Thrush Severe Diaper Rash
Recurrent Diaper Rash Ringworm Athletes Foot Whooping Cough

Has this child had excessive or recurrent problems with the following symptoms?

SYMPTOM	PAST	PRESENT	NO	DON'T KNOW	COMMENTS
Picky eater					
Craves certain foods					
Fatigue after meals					
Itching (where?)					
Hives					
Canker sores					

SYMPTOM	PAST	PRESENT	NO	DON'T KNOW	COMMENTS
Bad Breath					
Belching					
Gas					
Stomach aches					
Nausea					
Vomiting					
Bloating					
Constipation					
Diarrhea					
Seborrhea (cradle cap or dandruff)					
Eczema					
Other rashes					
Redness around anus					
Red cheeks					
Bedwetting					
Genital irritation					
Burning with urination					
Runny nose					
Stuffy nose					
Nosebleeds					
Rubbing nose					
Sneezing					
Tonsillitis					
Scratchy or sore throat					
Hoarseness					
Excessive Drooling					
Mouth Breathing					
Frequent cough					
Chest pain					
Wheezing or asthma					
Bronchitis or croup					
Reaction to bee stings					
Itchy or watery eyes					
Dark circles under eyes					
Puffy or red eyes					
Headaches					
Leg "aches"					
Night waking					
Nightmares					
Mood swings					
Hyperactivity					
Short attention span					
Behavior problems					
Learning disabilities					
Listlessness/fatigue					

SYMPTOM	PAST	PRESENT	NO	DON'T KNOW	COMMENTS
Ear Infections					
Fluid behind ear drums					
Hearing loss					
Sensitivity to sound					
Tugging or rubbing ears					
Speech problems					
Swelling (where?)					
Sweating					
Pallor or flushing					
Bruises easily					
Frequent low grade fevers					

HEALTH HISTORY

Has **this child** had any or the following:

	YES	NO	AGE	DESCRIBE (NUMBER)
Severe injuries				
Poisoning				
Hospitalizations (overnight)				
Convulsions from fever				
Epilepsy/seizures				
Heart problems (murmur)				
Eye or vision problems				
Hearing problems				
Surgery				
Pneumonia or bronchitis				
Allergies				
Birth defects				
Blood diseases				
Bone or joint disorders				
Cancer				
Diabetes				
Thyroid problems				
Kidney/bladder problems				
Mental retardation				
Muscle or Nerve disease				
High blood pressure				
Digestive disorders				
Skin disorders				
Liver diseases				
Cystic Fibrosis				
Other				

List any of the problems from the previous pages with **which any relative of this child** has had problems:

Mother ______________________________

Father ______________________________

Brother/Sister ______________________________

Other Relatives ______________________________

ENVIRONMENTAL SYMPTOMS

SYMPTOM	YES	NO	DON'T KNOW
Worse indoors			
Improved indoors			
Worse after 30 minutes in bed			
Symptoms worse in certain months Which months?			
Symptoms increase in cold weather			
Nasal symptoms without itchy eyes			
Worse in air conditioning			
Worse while dusting/sweeping			
Worse outdoors 4:30-8:30 P.M.			
Worse in cool evening air			
Worse in damp places			
Nasal symptoms playing on the lawn			
Worse playing in leaves			
Worse September until hard frost			
Symptoms increase around October 1st			
Symptoms worse on clear days			
Worse outdoors 7:00-11:00 A.M.			
Improved in the rain			
Improved in air conditioning			
Worse in basements			
Symptoms worse around feed mills			
Symptoms worse in barns			
Symptoms worse in certain homes Whose home? What is different?			
Symptoms worse in certain rooms (Which?)			
Symptoms worse at school/day care			
Symptoms worse in shopping mall			
Symptoms worse in church			
Symptoms worse in a car			
Symptoms worse at a gas station			
Symptoms worse in certain stores			
Symptoms worse working with paint, markers, etc.			
Symptoms worse around smokers			
Symptoms worse with a storm front			
Symptoms worse with wind			
Symptoms worse on rainy days			
Symptoms worse on dry days			
Symptoms worse with increased air pollution			
Symptoms worse around perfume			
Symptoms worse around scented items (detergents, soaps, candles, *etc.)*			
React to cats or in homes with cats (How?)			
React to dogs or in homes with *dogs (How?)*_			
React to other animals (which animals? How?).			
Does this child spend time around smokers? Whom?			
Does this child have any exposure to animals? Which? Where?			
Has this child had any previous allergy testing? What were the results?			

OTHER PROBLEMS YOUR CHILD MAY HAVE

	YES	NO
Feeling tired after a good nights sleep		
Problems with short term memory?		
Emotional swings		
Intolerance of cold weather		
Inappropriate weight gain		
Slowing of reflexes		

Please record this child's basal temperature for one week. (Temperature taken before getting out of bed in the morning.)

Circle one: Oral Axillary Rectal

Day One_________ Day Two_______ Day Three_________

Day Four_________ Day Five_______ Day Six_______

Day Seven_______

HOME ENVIRONMENT (Please circle all that apply and fill in blanks.)

House Apartment Mobile Home _______ # Years old

If multiple dwelling, what floor?______________________

On which floor is this child's bedroom?_________________

How long have you lived in this house?__________________

Region: City Residential City Industrial Suburban Small Town Rural

Garage: Attached Unattached

Is your basement ever damp? _________ Has it ever been flooded? _____________

Heating: Electric radiant Hot water/steam Gas forced air Fireplace/stove Space Heaters

Air Conditioning: Central Room Refrigerated Swamp cooler

Fuel: Electric Natural gas Propane Wood Oil Coal

APPLIANCE	GAS	ELECTRIC	AGE
Stove			
Dishwasher			
Refrigerator			
Microwave oven			
Clothes dryer			
Freezer			
Water heater			

FURNISHING AND HOUSEHOLD MAINTENANCE:

Upholstery: Cotton Silk Linen Wool Plastic Leather Synthetic

Padding: Cotton Dacron/polyester Foam Rubber

Mattress: Cotton Rubber Synthetic Plastic Covered Waterbed

Pillows: Feather Dacron/polyester Foam rubber Plastic covered

Carpet/rugs: Wool Cotton Synthetic Rubber backed
Jute backed Rubber or foam pad
Is this child's bedroom carpeted? Yes No

Window covering in this child's bedroom ______________________________

Blankets: Cotton Wool Synthetic

Cleaning agents used: Soap Detergents Scouring powder Bleach
Spray cleaners Air deodorizers Lysol Pinesol Ammonia
Fabric Softener (liquid or dryer sheets) Furniture polishes
Starch (spray or liquid) Floor wax

Other chemicals: Are there chemicals in the home used for work or hobbies, such as paints, adhesives, cleaning agents; etc.?(list) ______________________________

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What are your family's hobbies and/or interests? ______________________________

Has the house or yard been sprayed for pests or weeds? ______________________________

If so, list products and if this child had reactions to them. ______________________________

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PLEASE READ AND SIGN:

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE DOCTOR OF MY INSURANCE BENEFITS. I AM FINANCIALLY RESPONSIBLE FOR ALL DEDUCTIBLES, COPAYMENTS, AND CHARGES NOT COVERED OR NOT MEDICALLY NECESSARY BY MY INSURANCE CARRIER OR OTHER THIRD PARTY PAYER. IF I AM NOT COVERED BY INSURANCE I AM FINANCIALLY RESPONSIBLE FOR ANY CHARGES INCURRED ON THIS ACCOUNT. I AUTHORIZE THIS OFFICE TO RELEASE MEDICAL INFORMATION, FROM THIS OFFICE, TO MY INSURANCE COMPNY AS REQUESTED.

SIGNED ______________________________ **DATE** ______________________________
(INSURED PERSON)

SUPPLEMENTS OR NUMBING CREAM MUST BE PAID AT TIME OF SERVICE.