



**Pediatric Allergy, Asthma & Immunology**  
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**NEW PATIENT QUESTIONNAIRE**

NAME: \_\_\_\_\_ AGE: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

Primary/Referring Physician: \_\_\_\_\_ Phone #: \_\_\_\_\_

Other Subspecialists participating in care: \_\_\_\_\_

**I. MAIN PROBLEM TO BE ADDRESSED: (please check all that apply)**

- |  |   |  |                                      |
|--|---|--|--------------------------------------|
| <input type="checkbox"/> Asthma            | <input type="checkbox"/> Hay Fever      | <input type="checkbox"/> Sinus Problems  | <input type="checkbox"/> Infections: |
| <input type="checkbox"/> Cough             | <input type="checkbox"/> Headaches      | <input type="checkbox"/> Swelling (skin) | <input type="checkbox"/> Blood       |
| <input type="checkbox"/> Eczema            | <input type="checkbox"/> Hives          | <input type="checkbox"/> Food Allergy    | <input type="checkbox"/> Bone        |
| <input type="checkbox"/> Fire Ant Stinging | <input type="checkbox"/> Itching (skin) |  | <input type="checkbox"/> Ear         |
| <input type="checkbox"/> Food Allergy      |   |  | <input type="checkbox"/> Lung        |
|  |   |  | <input type="checkbox"/> Sinus       |
|  |   |  | <input type="checkbox"/> Skin        |
|  |   |  | <input type="checkbox"/> Throat      |

OTHER: \_\_\_\_\_

When did the problems begin? \_\_\_\_\_

How often do they occur? \_\_\_\_\_

What makes it better? \_\_\_\_\_ What makes it worse? \_\_\_\_\_

Is it worse during the morning? \_\_\_\_, noon/afternoon? \_\_\_\_, and/or nighttime? \_\_\_\_

During which months is it most severe? Jan Feb Mar April May June July Aug  
Sept Oct Nov Dec

What do you think triggers the problem?

- |  |                               |                                |                                   |                                 |
|--|-------------------------------|--------------------------------|-----------------------------------|---------------------------------|
| <input type="checkbox"/> Cats            | <input type="checkbox"/> Dogs | <input type="checkbox"/> Grass | <input type="checkbox"/> Pets     | <input type="checkbox"/> Stress |
| <input type="checkbox"/> Cigarette smoke | <input type="checkbox"/> Dust | <input type="checkbox"/> Heat  | <input type="checkbox"/> Perfumes |                                 |
| <input type="checkbox"/> Cold            | <input type="checkbox"/> Food | <input type="checkbox"/> Mold  | <input type="checkbox"/> Scents   | OTHER: _____                    |

**II. ALLERGY REVIEW:**

- |  |  |  |
|--|--|--|
| YES/NO   | YES/NO   | YES/NO                                       |
| <input type="checkbox"/> Nasal congestion                    | <input type="checkbox"/> Bad breath                  | <input type="checkbox"/> Heartburn           |
| <input type="checkbox"/> Runny nose                          | <input type="checkbox"/> Sinus infections            | <input type="checkbox"/> Hoarseness          |
| <input type="checkbox"/> Sneezing                            | <input type="checkbox"/> Ear infections              | <input type="checkbox"/> Itching (skin)      |
| <input type="checkbox"/> Loss of sense of smell              | <input type="checkbox"/> Cough                       | <input type="checkbox"/> Swelling (skin)     |
| <input type="checkbox"/> Itchy/watery eyes                   | <input type="checkbox"/> Wheezing                    | <input type="checkbox"/> Prior allergy tests |
| <input type="checkbox"/> Drainage down the throat            | <input type="checkbox"/> Shortness of breath:        | If "yes" Date _____                          |
| <input type="checkbox"/> Frequent throat clearing            | with exercise  | M.D. name _____                              |
| <input type="checkbox"/> Colored Nasal Discharge             | at night time  | <input type="checkbox"/> Prior allergy shots |
| <input type="checkbox"/> E.R. visits for asthma              | <input type="checkbox"/> Hospital stays for asthma # | If "yes" Date _____                          |
| Number in last year _____                                    | Number in last year _____                            | M.D. name _____                              |
| Most recent visit _____                                      | Most recent hospitalization _____                    |  |
| <input type="checkbox"/> Oral steroid requirement for asthma |  |  |
| Most recent course _____                                     |  |  |

Name: \_\_\_\_\_

DRUG "ALLERGIES"	REACTION	DATE NOTED
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____

FOOD "ALLERGIES"	REACTION	DATE OF LAST EPISODE
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____

CURRENT FOOD AVOIDANCES: \_\_\_\_\_

OTHER ALLERGIES:	REACTION	DATE NOTED
X-Ray Dye _____	_____	_____
Latex (rubber) _____	_____	_____

INSECT STINGS (please describe reaction): \_\_\_\_\_

**III. Birth History:**

	YES/NO
Product of full term pregnancy	___ ___
Vaginal delivery	___ ___
C-Section	___ ___
Complications before/during/after delivery	___ ___
Required prolonged hospitalization after delivery	___ ___

**IV. Past medical history** (please list all diagnosis):

- |    |     |
|----|-----|
| 1. | 7.  |
| 2. | 8.  |
| 3. | 9.  |
| 4. | 10. |
| 5. | 11. |
| 6. | 12. |

**V. Immunization History:**

\_\_\_ Up to date. \_\_\_ Records in chart.

**VI. Hospitalizations or Operations**

Type	Year	Reason

Name: \_\_\_\_\_

**VII. Family History:** (Please include pertinent conditions including asthma, allergies, spontaneous miscarriages, Early infant deaths, recurrent infection).

	Age	Medical Problems	Pertinent Conditions
Father			
Mother			
Sibling M/F			
Sibling M/F			
Sibling M/F			
Sibling M/F			

**VIII. Social history:**

1. Live at home with: \_\_\_Mother \_\_\_Father \_\_\_Siblings\_\_\_\_\_
2. Secondary tobacco exposure? Yes/No If yes, who smokes\_\_\_\_\_ (Please include all family members)
3. Preschool. Yes/No (please circle appropriate response) Daycare. Yes/No School:\_\_\_\_\_ (Name and Grade)
4. Number of days absent due to asthma, allergy or infection in past year\_\_\_\_\_.
5. Pets:\_\_\_\_\_ (circle appropriate response(s) inside, outside, both, sleep in bedroom.)  
(Dog/Cat/Other) Increased allergy symptoms around animals? Yes/No
6. Age of home:\_\_\_\_\_.
7. Flooring: (please circle appropriate response(s) carpet, tile, hardwood, throw rugs, other:\_\_\_\_\_)
8. Bedroom furniture: (please circle appropriate response(s) box spring/mattress, waterbed, stuffed chair, throw pillows, down pillows and/or comforter, tapestries).
9. Window coverings: (please circle appropriate response(s) cloth, wood blinds, metal/plastic blinds.)
10. Do you have (please circle appropriate response(s) ceiling fan, box fan, oscillating fan.)
11. Do you have evidence of (please circle appropriate response(s) water damage (floods, leaks) in your home? Yes/No
12. Does your home have (please circle appropriate response(s) central air/heat/window units.)

Name: \_\_\_\_\_

### PATIENT HISTORY: REVIEW OF SYSTEMS

Please check any problems (boxes) listed below which have significantly affected your child.  
(If left "unchecked" the presence of the problem is denied).

Person completing form  Patient  Mother  Father  Legal guardian  Other \_\_\_\_\_

Patient's Name \_\_\_\_\_ Date \_\_\_\_\_

#### Constitutional

Recent weight gain \_\_\_\_\_ (amount)

Recent weight loss \_\_\_\_\_ (amount)

Fever

Frequent Infections

Type of Infections:

\_\_\_ Throat Infections

\_\_\_ Ear Infections

\_\_\_ Sinus Infections

\_\_\_ Pneumonia

\_\_\_ Blood Infections

\_\_\_ Skin Infections

\_\_\_ Bone Infections

#### Eyes

Pain

Redness

Itching eyes

#### Ears–Nose–Mouth–Throat

Nosebleeds

Loss of smell

Dryness in nose

Runny nose

Oral Thrush

Hoarseness

#### Cardiovascular

High blood pressure

Heart murmurs

Shortness of breath

#### Respiratory

Cough

Wheezing

#### Gastrointestinal

Vomiting

Persistent diarrhea

Reflux

#### Genitourinary

*For Women Only:*

Age when periods began: \_\_\_\_\_

Periods regular?  Yes  No

How many days apart? \_\_\_\_\_

Date of last period? \_\_\_ / \_\_\_ / \_\_\_

#### Dermatologic (skin)

Hives

Eczema

Rash (other) \_\_\_\_\_

Yeast Infections

#### Neurological System

Headaches

#### Musculoskeletal

Joint pain

Joint swelling

Physician Initials \_\_\_\_\_

Parent Signature \_\_\_\_\_

Name: \_\_\_\_\_

**MEDICATIONS**

Drug allergies:  No  Yes To what? \_\_\_\_\_

Type of reaction: \_\_\_\_\_

**PRESENT MEDICATIONS** (List any medications you are taking. Include such items as aspirin, vitamins, laxatives, calcium and other supplements, etc.)

Name of Drug	Dose (include strength & number of pills per day)	How long have you taken this medication	Please check: Helped?		
			A Lot	Some	Not At All
1.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Natural or Alternative Therapies (chiropractic, magnets, acupuncture, massage, over-the-counter preparations, etc.)

\_\_\_\_\_