Boston Children's Hospital

LABEL OR PRINT
NAME

CH MRN

# ALLERGY/IMMUNOLOGY NEW PATIENT QUESTIONNAIRE



| | |
|---|---|
| **Name:** | **Date of Birth:** |
| **Pharmacy Name:** | **Pharmacy Address:** |
| **Specialty Pharmacy Name:** | |

**I want to know:**

**My questions are:**

**I don't want to leave without this (asthma or epinephrine action plan, prescription, etc):**

## REVIEW OF SYSTEMS

**Has your child been experiencing or diagnosed with any of the following?**
Please check any that apply

**General**
- ☐ Feeling tired
- ☐ Fevers
- ☐ Chills or night sweats
- ☐ Poor weight gain
- ☐ Changes in appetite

**Eyes**
- ☐ Red or itchy eyes
- ☐ Blurred or altered vision
- ☐ Sensitivity to light

**Ear/Nose/Throat**
- ☐ Nasal congestion/snoring
- ☐ Post nasal drip/nasal discharge
- ☐ Ear or throat pain
- ☐ Nose bleeds
- ☐ Nasal polyps
- ☐ Loss of smell

**Urinary**
- ☐ Pain with urination
- ☐ Increased frequency of urination
- ☐ Urine infections

**Lungs**
- ☐ Cough
- ☐ Shortness of breath
- ☐ Wheezing

**Heart**
- ☐ Heart murmur
- ☐ Heart palpitations/irregular heartbeat
- ☐ Heart defects

**Gastrointestinal**
- ☐ Diarrhea
- ☐ Constipation
- ☐ Abdominal pain
- ☐ Nausea/Vomiting
- ☐ Acid reflux/heartburn
- ☐ Blood in stool
- ☐ Enlarged liver or spleen

**Blood**
- ☐ Easy bruising or bleeding
- ☐ Swollen glands
- ☐ Anemia
- ☐ Low white blood cell/platelet counts

**Endocrine**
- ☐ Excessive thirst
- ☐ Hot or cold intolerance
- ☐ Thyroid disorders
- ☐ Diabetes
- ☐ Delayed puberty

**Skin**
- ☐ Rash
- ☐ Birth marks or large moles

**Bones/joints**
- ☐ Muscle pain
- ☐ Joint pain/swelling

**Neurologic**
- ☐ Headaches
- ☐ Dizziness or lightheadedness
- ☐ Weakness/numbness/tingling
- ☐ Seizures

**Psychiatric**
- ☐ Hyperactivity disorder
- ☐ Depression or anxiety
- ☐ Sleep disturbances

**Continued on other side**

BOSTON CHILDREN'S HOSPITAL, 300 LONGWOOD AVE., BOSTON, MA 02115

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# ALLERGY/IMMUNOLOGY NEW PATIENT QUESTIONNAIRE



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**Has your child been diagnosed or suspected to have any of the following:**

**Asthma?** ☐ **Yes** ☐ **No**
**If yes:** Has your child been hospitalized? ☐ Yes ☐ No
Has symptoms with exercise/activity? ☐ Yes ☐ No
Taken oral steroids? ☐ Yes ☐ No If yes, how often? _____

**Eczema?** ☐ **Yes** ☐ **No**
**If yes:** What skin moisturizers are used? _____
How often does your child bathe? _____
Difficulty sleeping due to itching? ☐ Yes ☐ No
Has your child had skin infections? ☐ Yes ☐ No

**Nasal/Eye Allergies?** ☐ **Yes** ☐ **No**
**If yes:** What symptoms? ☐ Sneezing ☐ Congestion ☐ Post-nasal drip ☐ Runny nose ☐ Red itchy eyes
Other symptoms: _____
What triggers your child's symptoms? _____
What seasons are worse? ☐ Spring ☐ Summer ☐ Fall ☐ Winter ☐ Always bad

**Increased frequency/severity of infections?** ☐ **Yes** ☐ **No**
**If yes:** What type of infections? ☐ Ear infections ☐ Sinus infections ☐ Pneumonias ☐ Bronchitis ☐ Other
How many courses of antibiotics has your child taken in the past 12 months? _____

**Food allergies?** ☐ **Yes** ☐ **No**
**If yes, please list foods restricted:** _____

**Has your child had any other medical problems or diagnoses?** _____
_____

**Has your child been hospitalized or had any surgeries? If yes, please describe:** _____
_____

**List any medication allergies:** _____

**Are your child's immunizations up to date?** ☐ **Yes** ☐ **No ; Did your child receive the influenza vaccine this year?** ☐ **Yes** ☐ **No**

**FAMILY HISTORY: Please indicate if the patient's parents or siblings have had any of the following conditions:**

| | Asthma | Nasal/Eye Allergy | Eczema | Food Allergy | Drug Allergy | Immune Deficiency |
|---|---|---|---|---|---|---|
| **Biological Mother** | | | | | | |
| **Biological Father** | | | | | | |
| **Child's Brothers and Sisters** | | | | | | |

**ENVIRONMENTAL HISTORY:**

**Does your child live in:** ☐ An apartment ☐ A house ☐ A multifamily house/condo ☐ Other: _____
☐ Multiple home settings: _____

**Do you have a basement?** ☐ Yes ☐ No **If Yes:** Is it ☐ Finished ☐ Dry ☐ Damp ☐ Has flooded

**Climate control:** ☐ Hot water heat ☐ Steam heat ☐ Forced hot air ☐ Wood stove ☐ Space heater
☐ Central AC ☐ Window A/C ☐ Air filters ☐ Air cleaner/purifier
☐ Humidifier ☐ Dehumidifier ☐ Other: _____

**Does your home have?** ☐ Mold or mildew ☐ Damp or musty smell ☐ Water stains ☐ Mice ☐ Cockroaches ☐ None

**Flooring:** ☐ Hardwood ☐ Tile/linoleum ☐ Wall to wall carpeting ☐ Area rugs ☐ Other: _____

**Exposure to pets?** ☐ No ☐ Yes (If yes, please describe): _____

**Do you or any of your child's caretakers smoke?** ☐ No ☐ Yes

**Does your child's bedroom have?** ☐ Stuffed animals ☐ Rugs ☐ Carpeting ☐ Blinds ☐ Curtains
☐ Air conditioning ☐ Humidifier ☐ Feather pillow ☐ Down comforter
☐ Air cleaner/purifier ☐ Allergy-proof mattress or pillow covers

**School, work, or day care environment (please describe):** _____

| Patient/Patient Representative Signature | Name (printed): | Relationship to patient or Patient | Time | Date |
|---|---|---|---|---|