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

Allergy & Asthma Medical Group

DTF1373

PATIENT INFORMATION

Name: _____
MR#: _____ Finance: _____
DOB:

Pediatric Allergy History Questionnaire

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

Date filled out: _____

RCHSD patient number: _____

What is the main reason you/ your child are being seen in the Allergy/Immunology clinic?

_____

_____

Please answer the following questions to help us learn more about your child:

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

Has your child been diagnosed as having asthma? ☐ Yes ☐ No At what age (best estimate)? _____

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

☐ cough ☐ wheeze ☐ shortness of breath ☐ chest tightness ☐ limited in running, playing

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

Is there a certain time 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, strong smells ☐ cold air ☐ windy weather

☐ respiratory infections ("colds") ☐ exercise ☐ other (list) _____

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

Has your child ever been in the ICU for breathing problems, asthma? ☐ Yes ☐ No Date(s): _____

In the ICU, has your child needed an airway tube and ventilator machine to breathe? ☐ Yes ☐ No Date(s): _____

How many times has your child had to be treated with oral steroids (e.g. prednisone, prednisolone, Prelone, dexamethasone, Decadron, Medrol) in the past 1 year? _____

Has your child had "bronchitis"? ☐ Yes ☐ No How often in the last few years? _____

Has your child ever had "pneumonia"? ☐ Yes ☐ No If yes, how many episodes total in his/her life?
_____

How many school days has your child missed this school year due to asthma/chest symptoms? _____

How many days of work have you missed due to your child's asthma/chest symptoms in the last year?
_____

How often does your child have daytime cough or wheeze problems? ☐ every day ☐ often ☐ sometimes ☐ rare
Does your child cough at night while asleep? ☐ Yes ☐ No If yes, how often? ☐ every night ☐ often ☐ sometimes
How many nights has your child awoken from sleep because of asthma, or symptoms of wheezing or cough in the last 4 weeks? _____
How many days or nights in the past 4 weeks has your child needed to use their as needed inhaler or nebulizer to treat their asthma, or their wheezing or cough? _____
Does your child have a peak flow meter: ☐ Yes ☐ No If Yes, his/her best peak flow reading:_____

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 ☐snoring ☐ mouthbreathing ☐ watery eyes ☐ red eyes ☐ itchy eyes ☐eye rubbing ☐ itchy ears ☐ itchy throat ☐ post nasal drip ☐ throat clearing ☐throat clucking

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

In which seasons do 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 your child's nose/eye symptoms worse: ☐ cats ☐ dogs ☐ dust ☐ grass ☐ smoke ☐ fumes, strong smells ☐ cold air ☐ certain locations: _____

☐ other: _____

Has your child ever had allergy skin testing or blood testing? ☐ No ☐ Yes If yes, when? _____

If yes, check those tests that were positive: ☐ dust mite ☐ pollen ☐ mold ☐ animal hair ☐ foods ☐ I don't remember

Has your child ever been on allergy shots before? ☐ Yes ☐ No If yes, what dates? _____

3. SINUS INFECTIONS, EAR INFECTIONS (if none, go to section 4)

Has your child had frequent ear infections? ☐ Yes ☐ No If yes, how many in the last year? _____

Has your child had sinus infections? ☐ Yes ☐ No If yes, how many in the last year? _____

At what age did the ear or sinus infections start? _____

How many times have antibiotics been needed in the last year for either sinus or ear infections? _____

Does your child respond well to antibiotic therapy, when he/she uses them? ☐ Yes ☐ No

Has your child needed to see the ear/nose/throat (ENT) doctor? ☐ Yes ☐ No If yes, when? _____

Have any tests been done for your child's ear and/or sinus infections (e.g. x-rays) ? ☐ Yes ☐ No If yes, what tests?

_____

4. ECZEMA (CHRONIC DRY ITCHY SKIN) (if none go to section 5)

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

Check the body parts that have eczema rash: ☐ face ☐ neck ☐ scalp ☐ arms ☐ elbows ☐ wrists ☐fingers ☐ legs ☐ knees ☐ ankles ☐ feet ☐ chest ☐ abdomen ☐ back

How frequent is the rash? ☐ occasional, comes and goes ☐ much of the time ☐ most or all of the time

How bad is the eczema rash? ☐ mild ☐ moderate ☐ severe

Overall, as your child gets older, is the rash (pick one): getting better? ☐ getting worse? ☐ staying the same? ☐

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

_____

Are there any non-food triggers for the eczema? _____

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

Food	Hives	Eczema	Vomiting/ diarrhea	Throat itch, swelling	Facial Swelling	Wheeze, cough	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 you/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? _____
Does your child have a self-injecting epinephrine device, like EpiPen or Auvi Q? ☐Yes Which one? _____ ☐No

6. HIVES (if none, go to section 7)

Does your child get hives or swelling? ☐ Yes ☐ No
If yes, how often? ☐ daily ☐ frequent ☐ often ☐ occasional ☐ rare
Where do the hives/swelling occur on the body? ☐ everywhere ☐ face mainly ☐ lips mainly ☐ trunk, abdomen mainly
☐ extremities mainly ☐ feet mainly ☐ hands mainly
Is there a trigger for the hives? ☐ food ☐getting hot ☐ cold exposure ☐ pressure ☐ other: _____
Do the hives get better with using an antihistamine (e.g. Benadryl, Claritin, Zyrtec, Allegra)? ☐ Yes ☐ No
Have any tests been done to evaluate the hives? ☐ Yes ☐ No If yes, what tests, and what were the results?
_____

7. INSECT STING REACTIONS (if none, go to section 8)

Has your child had a bad reaction (e.g. hives, wheezing, swelling, paleness, etc.) to a sting by a:

☐ bee ☐ wasp ☐yellow jacket ☐ hornet ☐ ant ☐ other: _____

Describe the reaction: _____

How many reactions have occurred? _____

When was the latest reaction? _____

Has your child been prescribed an epinephrine autoinjector, like EpiPen or AuviQ? ☐ Yes ☐ No If yes, which_____

Does your child get large local swelling reactions to stinging insects? ☐ Yes ☐ No If yes, describe what happens:
_____

8. MEDICATION ALLERGIES, AND OTHER TYPES OF ALLERGIES

Is your child considered allergic to any antibiotics, or other medication? ☐ Yes ☐ No

If yes, give details of what happened

- which medication? _____
- what kind of a reaction? _____
- when did it occur? _____

Is your child allergic to latex (balloons, rubber, or elastic) ☐ Yes ☐ No

If yes, give details of what happened: _____

Does your child have any allergies to substances contacting their skin? ☐ Yes ☐ No

If yes, give details: _____

MEDICATIONS (please check all your child has used or tried in the past):

Inhalers: ☐Albuterol (ProAir, Ventolin, Proventil, Xopenex) ☐ Ipratropium (Atrovent) ☐ Combivent
☐Flovent ☐Qvar ☐Pulmicort
☐ Alvesco ☐Asmanex ☐ Aerospan
☐Advair ☐Symbicort ☐ Dulera
☐Serevent ☐Foradil
☐Other: _____

Nebulized medications: ☐albuterol ☐Xopenex ☐Pulmicort (budesonide) ☐Atrovent ☐Combivent

Nasal Sprays: ☐fluticasone (Flonase) ☐Nasonex ☐Rhinocort ☐Nasacort ☐Veramyst
☐ Astelin ☐Astepro ☐Patanase
☐Atrovent-Nasal ☐Afrin ☐ neosynephrine ☐nasal saline

Antihistamines: ☐Zyrtec (cetirizine) ☐Claritin (loratadine) ☐Allegra (fexofenadine) ☐Clarinex ☐Xyzal
☐Benadryl (diphenhydramine) ☐Atarax (hydroxyzine) ☐Other OTC meds:
_____

Skin preparations: ☐hydrocortisone ☐Aclovate ☐triamcinolone ☐Kenaloq ☐Elocon ☐Cutivate
☐Elidel ☐Protopic ☐Other: _____

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

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

_____ _____
_____ _____
_____ _____
_____ _____

ENVIRONMENT

Check any pets you have: ☐dog(s) nr: ____ indoors and/or outdoors? (circle)
☐ cat(s) nr.: ___ indoors and/or outdoors? (circle)
☐ hamster ☐ guinea pig ☐ other: _____

Do any members of your household smoke: ☐ Yes ☐ No <u>Inside</u> the house or car? ☐ 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 parents ☐ other (such as sofa)

Is there a 2nd household where he/she stays? ☐ Yes ☐ No If yes, where _____

FAMILY HISTORY (**Check all that apply):**

Relative	Asthma	Nasal allergy (e.g hay fever)	Eczema	Food allergy	Hives
Mother					
Father					
Brother or Sister					
Uncles, Aunts					

List other diseases that run in the family: _____

PAST MEDICAL HISTORY

List by date any hospitalizations for problems other than asthma, and the reason:

_____
_____
_____

List any surgeries and dates·

_____
_____

List your child's birth weight : _____ Was your child premature? ☐ No ☐ Yes
List any newborn problems (if applicable): _____

List any other medical problems your child has:

OTHER REVIEW OF SYSTEMS (check yes or 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 abdominal pain often? ☐ Yes ☐ No	
	Does your child have difficulty swallowing, pain with swallowing	Yes No
	Does your child have heartburn? History of GE reflux?	Yes No
	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:

Signature _____

Printed name: _____

Relationship: _____

Parent/Guardian Date____/____/____ Time: ____ Provider Date____/____/____ Time: ____