PEDIATRIC ALLERGY DATA BASE & HEALTH HISTORY

Dear Parents:

Welcome! Please fill in this form and return it to our office before your scheduled appointment. 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 as complete as possible.

Thank you!

Name: _____ D.O.B.: _____
(Last, First, Middle)

What are your major concerns about your child's health? _____
_____
_____

Who referred you to us? _____
Who is your child's pediatrician? _____
List other doctors your child sees. _____
_____

List dates of your child's immunizations.

Diphtheria/tetanus/pertussis (DTP) _____
Or Diphtheria/tetanus (DT) _____
Td (Boosters) _____
Polio _____
Measles/mumps/rubella (MMR) _____
Hemophilus Influenza B (Hib) _____
Other (Flu shots, etc.) _____
Tuberculosis skin test (Tine or PPD) _____
Did this child have any severe reactions to any immunization? _____
If so, please list and describe. _____
_____

PREGNANCY & BIRTH

Did you have any problems while pregnant with this child?

	YES	**NO**
Toxemia (Preeclampsia)		
High blood pressure		
Albumin or protein in your urine		
Diabetes (sugar in your urine)		
Anemia (low iron in your blood)		
Have urinary (bladder) infections		
Have a sexually transmitted disease:		
Gonorrhea		
Chlamydia		
Trichomoniasis		
Herpes		
Have yeast vaginal infections		
Have any other illnesses or infections		

	YES	NO
Premature labor		
Spotting/bleeding (when?)		
Allergies (what type?)		

Did you use any of the following substances during your pregnancy?

	YES	NO
Antibiotics		
Allergy medicines		
Vitamins/minerals		
Cigarettes (how many packs per day?)		
Alcohol		
Recreational (street) drugs		
Rho Gam		
Other medications (list them)		

Were there certain foods you craved or ate a lot of during this pregnancy, including foods your doctor recommended? If so, list them. _____

_____

_____

Did you (mother) have any serious problems during labor or delivery? _____

_____

How long was your pregnancy? _____(weeks/months)
Where was this child born? (circle) HOME HOSPITAL
Name and location of hospital: _____
Who was your obstetrician? _____
Was this a vaginal or cesarean birth? (circle) VAGINAL CESAREAN
If cesarean, what was the reason? _____
Baby's position during labor: (circle) HEAD DOWN FEET FIRST BOTTOM FIRST TRANSVERSE

Did you have any medications during labor and delivery?

	YES	NO
Pain medication during labor		
Pitocin to start or accelerate labor		
Epidural or spinal anesthesia		
General anesthesia (completely asleep)		
Paracervical block		
Local anesthesia (for episiotomy/stitches)		
Other		

Did the baby have any of the following problems during labor and delivery?

	YES	NO
Slow heartbeat (fetal heart tones)		
Meconium (bowel movement before birth)		
Cord around the baby's neck		
Baby's head or shoulders too big		
Forceps used		
Suction used (for delivery)		
Very long labor		

	YES	NO
Precipitous (short or hard labor)		
Baby slow to breathe after birth		
More than one baby born		
Other		

Did you know what the baby's APGAR scores were? _____
What was this child's birth weight? WEIGHT _____ LENGTH _____
HEAD CIRCUMFERENCE _____

Did your child have any of the following problems as a newborn?

	YES	NO
Breathing problems		
Needed oxygen		
Jaundice		
Seizures (convulsions)		
Infections		
Needed transfusion		
Low blood sugar (hypoglycemia)		
Birth defects		
Other		

MATERNAL & FAMILY HISTORY

How many children have you (mother) had? _____
Which one is this child? (birth order) _____
Have you (mother) had any premature births? _____
Have you (mother) had any 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? (circle) YES NO
If yes, for how long? _____
Did you have problems with nursing this child?

	YES	NO
Not enough milk		
Sore nipples		
Mastitis (breast infections)		
Foods in your diet bothered this child		
If so, list the foods and the problems noticed.		

Did this child gain weight well in infancy? (circle) YES NO
Was formula used? (circle) YES NO
If yes, did you need to switch brands? _____
List all formulas used and problems noted with each: _____
_____
_____

At what age did your child first eat solids (baby food)?

	MONTHS
Cereal	
Vegetables	
Fruits	
Meats	
Juices	
Cow's milk (not formula)	

Has your child had problems with any foods?

FOOD	**IN INFANCY**	**NOW**	**SYMPTOMS**
Milk			
Wheat			
Eggs			
Corn			
Sugar			
Citrus			
Chocolate			
Colorings			

Did/does this child have colic? (circle) YES NO Until what age? _____

Has your child ever had any of the following symptoms?

	YES (In Past)	**YES (Now)**	**NO**	**DON'T KNOW**
Picky eater				
Craves certain foods				
Excessively sleepy after meals				
Itching (where?)				
Hives				
Canker sores				
Bad breath				
Belching				
Gas				
Stomach aches				
Nausea				
Vomiting				
Bloating				
Constipation				
Diarrhea				
Seborrhea (cradle cap or dandruff)				
Eczema				
Other rashes				
Redness around anus				

	YES (In Past)	YES (Now)	NO	DON'T KNOW
Red cheeks				
Bedwetting (after toilet trained)				
Daytime wetting				
Vaginal or penile irritation				
Burning with urination				
Runny nose				
Stuffy nose				
Nosebleeds				
Rubbing nose				
Sneezing				
Large tonsils				
Scratchy or sore throat				
Hoarseness				
Excessive drooling (past teething age)				
Mouth breathing				
Frequent cough				
Chest pain				
Wheezing or asthma				
Bronchitis or croup				
Itchy or watery eyes				
Dark circles under eyes				
Puffy or red eyes				
Headaches				
Leg aches ("growing pains")				
Night waking				
Nightmares or night terrors				
Mood swings				
Hyperactivity/impulsive behavior				
Short attention span				
Behavior problems				
Learning disabilities				
Listlessness/fatigue				
Ear infections				
Fluid behind the eardrums				
Hearing loss				
Sensitive to sound (unusually so)				
Tugs or rubs ears (or says ears itch)				
Speech problems (or slow to talk)				
Swelling (where?)				
Excessive sweating				
Pallor or flushing				
Bruises easily				
Frequent low grade fevers				

HEALTH HISTORY

Has your child had any of the following?

	YES	NO	AGE	DESCRIBE
Severe injuries				
Poisoning				
Hospitalization (overnight)				

	YES	NO	AGE	DESCRIBE
Convulsions from fever				
Epilepsy/seizures				
Heart murmur				
Vision problems				
Hearing problems				
Chickenpox				
Strep infections				
Yeast infections:				
Thrush/candida/monilia				
Severe diaper rash				
Fungal infections:				
Ringworm				
Athlete's foot				
Other fungal infections				
Surgery (including ear tubes)				
Pneumonia or bronchitis				

MEDICATIONS

Is your child taking medication now? If so, please list. _____

_____

List any medications your child takes frequently. _____

_____

Are there any medications your child has had a bad reaction to? Please list and describe the reaction. _____

_____

Please circle the drugs your child has been given.

ANTIBIOTICS STEROIDS (Prednisone, Decadron) ASPIRIN
ACETAMINOPHEN ANTIHISTAMINES DECONGESTANTS
COUGH SUPPRESSANTS CODEINE OR OTHER NARCOTICS
Other: _____

_____

Has this child ever been tested and/or treated for allergies? (circle) YES NO
Please describe type of tests, treatment, and doctor: _____

_____

_____

FAMILY HEALTH HISTORY

	MOTHER	FATHER	SIBLINGS	OTHER RELATIVES	EXPLAIN
Allergies					
Birth defects					
Blood diseases					
Bone/joint disorders					
Cancer					
Chronic lung disease					
Eye diseases (glaucoma, etc.)					
Lazy eye or strabismus					
Near or far sighted					
Diabetes					
Thyroid problems					

	MOTHER	FATHER	SIBLINGS	OTHER RELATIVES	EXPLAIN
Heart disease					
Kidney/bladder problems					
Mental retardation					
Muscle disease					
Nerve disease					
Psychiatric condition					
Yeast infections					
High blood pressure					
Digestive disorders					
Irritable bowel					
Skin disorders					
Liver diseases					
Cystic Fibrosis					
Other					

ENVIRONMENTAL SYMPTOMS:

	YES	NO	DON'T KNOW
Worse indoors			
Improved indoors			
Worse after 30 minutes in bed			
Symptoms increase in cold weather			
Nasal symptoms without itchy eyes			
Worse in air conditioning			
Worse while dusting/sweeping			
Worse outdoors 4:30pm-8:30pm			
Worse in cooling evening air			
Worse in damp places			
Nasal symptoms playing on lawn			
Worse playing in leaves			
Worse September until hard frost			
Symptoms increase around October 1st			
Symptoms worse on clear days			
Worse outdoors 7:00am-11:00am			
Improved in air conditioning			
Improved in rain			
Worse in basements			
Symptoms worse around feed mills			
Symptoms worse in barns			
Symptoms worse in certain homes (whose home?)			
Symptoms worse at school/day care			
Symptoms worse in shopping mall			
Symptoms worse in certain room			
Symptoms worse in church			
Symptoms worse in car			
Symptoms worse at a gas station			
Symptoms worse in certain stores			
React to cats or in home with cats			
React to dogs or in home with dogs			
React to other animals (which animals?)			

	YES	NO	DON'T KNOW
Symptoms worse in certain months (which months?)			
Symptoms worse working with paint, markers, etc.			
Symptoms worse around smokers			
Symptoms worse with storm front			
Symptoms worse with wind			
Symptoms worse on rainy day			
Symptoms worse on dry day			
Symptoms worse in air pollution			
Do certain odors bother this child?			

Can your child have a good nights rest, wake up in the morning, and still feel tired?
YES NO
Does your child have problems with short-term memory?
YES NO
Does your child have greater emotional swings than you think he/she should have? (depression-downs, stimulation-ups, that you observe)
YES NO
Does your child not tolerate cold weather? (i.e., needs to wear more clothes than others to stay warm)
YES NO
Do you think this child's reflexes are as quick as they used to be?
YES NO
Is this child gaining more weight than you think appropriate for the amount of food eaten?
YES NO

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

Temperature taken: Oral _____ Rectal _____ Axilla _____
Day One: _____ Day Four: _____ Day Six: _____
Day Two: _____ Day Five: _____ Day Seven: _____
Day Three: _____

HOME ENVIRONMENT: (Please circle all that apply and fill in the blanks.)
House Apartment Mobile home _____ (# of years old)
If multiple dwelling, what floor? _____
Which floor is the child's bedroom? _____
How long have you lived in this house? _____
Region: City-residential City-industrial Suburban Small town Rural
Garage: Attached Detached
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

Appliances:

	GAS	ELECTRIC	AGE
Stove			
Dishwasher			
Refrigerator			
Microwave oven			
Clothes dryer			
Deep freeze			
Water heater			

Furnishings 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/foam pad
Is child's bedroom carpeted? YES NO
Window covering in 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)
Starch (spray or liquid) Furniture polish Floor wax
Other chemicals: Are there chemicals in the home used for work or hobbies such as paints, adhesives, cleaning agents, etc.? _____
Please list. _____
_____
Has the house or yard been sprayed for pests or weeds? YES NO
If so, list products used. _____
_____

PERSONAL CARE PRODUCTS: (List brands used by this child and other family members.) Note: If this child is currently nursing, pay special attention to products used by mother.

	CHILD	OTHER
Body/face soap		
Shampoo		
Cream rinse		
Lotion		
Bubble bath/oil		
Deodorant		
Perfume		
Shaving cream		
Aftershave		
Hair spray, etc.		
Diaper cream/powder		
Other		

Does this child spend time around any smokers? YES NO Whom? _____
_____ Menthol or regular cigarettes?
Does the smoke bother the child? YES NO Explain: _____
_____

Please note here anything you would like us to know about your child and the problems for which you are seeking our help, which may not have been covered in this questionnaire.