Children's Mercy Northland
Allergy, Asthma and Immunology Initial Visit
Patient Questionnaire

Allergy Questionnaire

To obtain the most accurate and complete information regarding your visit we ask that you answer the following questions regarding the patient to be seen. Please circle the appropriate *italicized* answer when possible.

Many initial visits in the Allergy Clinic will take 1-2 hours to complete so plan your time accordingly. Please remember to arrive on time, bring your current medications, and bring copies of any recent test results for review.

Patient Name: ____
Parent Name: ____
Primary Care Physician: ____
Name of physician who referred you to the clinic: ___________________________

Reason for this visit:
Please provide a very brief description of the reasons for this visit. The physician will review this in further detail during the appointment. ____
____

Past Medical History: (please remember to circle the appropriate *italicized* answer when possible)
Was your child born within two weeks of the expected due date? *Yes* *No*
If your child was born early (preterm) then how many weeks early was he/she born? __________
How much did your child weigh at birth? ______________________________
Did you or your child have any problems with the pregnancy, delivery or newborn period? *Yes* *No*
If yes, what problems? ____
Is your child adopted? *Yes* *No*
Does your child have any recurrent or long term medical problems? *Yes* *No*
If yes, please specify: ____
Has your child ever been admitted to a hospital or had an overnight hospital stay? *Yes* *No*
Is yes, for what reasons? ___________________________
Has your child ever been admitted to the Intensive Care Unit (ICU)? *Yes* *No*
Has your child ever required intubation or mechanical ventilation? *Yes* *No*
Has your child required surgery? *Yes* *No*
If yes, what type of surgery and when did this occur? ____________________________
Has your child had radiographic imaging (i.e. chest x-ray, CAT scan)? *Yes* *No*
If yes, what imaging and when? ___________________________________

Medicines: (list name, dosage and frequency of use)
____
____
____

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Allergies:
Has your child had any allergies or side effects to medicines, foods or latex exposure? *Yes* *No*.
If yes, please specify: ____

Immunizations:
Are your child's immunizations (vaccinations) up to date? *Yes* *No*
Has your child received the influenza (flu) immunization this year? *Yes* *No*

Family History:
Please circle any illnesses that occur within the family. For this response include immediate family members (mother, father, brothers and sisters) and the patient's grandparents. Do not include the patient that is being seen in the Allergy Clinic.

Asthma	Swelling (angioedema)	Other: ______________
Hayfever (allergic rhinitis)	Cystic fibrosis	____________________
Sinus infections (sinusitis)	Emphysema/COPD	____________________
Eczema/Atopic dermatitis	Tb (tuberculosis)	____________________
Hives (urticaria)		If no family illnesses check box □

Social History:
With whom does your child live? *mother* *father* *siblings (how many_____)* *others:_____________*
Does your child attend daycare? *Yes* *No*
Does your child attend school? *Yes* *No*
If yes, what grade? ______________________
Mother's occupation: ____________________ Father's occupation: ____________________

Environmental History:
Do you live in a: *house* *apartment* *condominium* *duplex* *mobile home* *other:* _________
How old is your home? ______________________
Is your home heated by: *gas* *electric* *propane* *wood* *other:* ______________________
Is your home cooled by: *central air conditioning* *window air conditioning* *fans* *none*
Does your house have a basement or crawlspace? *Yes* *No*
If you have a basement or crawlspace would you describe this area as: *dry* *damp* *wet*
What type of flooring is in your child's bedroom? *carpet* *wood* *tile* *other:* ______________
Are there any pets in the house? *Yes* *No*
If yes, specify what type and how many? ______________________________________
Is there tobacco use in the family? *Yes* *No*

Thank you for completing this form. Please provide any additional comments to the physician.