New Patient Form—Pediatric Allergy Center

- **Please complete this form now.**
- **Bring it with you on the day of your appointment.**
- **It helps us if you read the questions carefully and answer them as fully as possible.**
- **If there are questions or medical terms that are not clear, please ask us when you come in.**

General Information

Child`s Name: _____
Age: _____ **Date of Birth:** _____
Your best contact number: _____
Your Child`s Primary Care Provider: _____
Name of the doctor who recommended your visit: _____

What is the main reason for your visit? Please list the main reasons for your visit:

_____
_____
_____
_____
_____
_____
_____
_____

Please list any questions/concerns that you would like discussed during this visit and what you would like to accomplish with today`s visit?

_____
_____
_____
_____
_____
_____

Medicines

Please list all the medications your child is taking (including inhalers, nasal sprays, over the counter medications, prescription creams/lotions/ointments): _____
_____
_____
_____
_____

Immunizations

Are immunizations up to date? Yes ☐ No ☐ **Received flu vaccine before?** Yes ☐ No ☐

Any complications after vaccines: _____

Your Child's Medical, Allergy and/or Asthma History

Does your child have any of the following? Please check any that apply.

Stuffy nose (nasal congestion) ☐	Coughing up mucous (sputum) ☐	Hives ☐
Loss of smell ☐	Hard time exercising ☐	Heart murmur ☐
Watery (runny) nose ☐	Stomach pain ☐	Drug reactions ☐
Postnasal drip ☐	Diarrhea ☐	Vaccine reactions ☐
Itchy nose ☐	Vomiting ☐	Skin rashes or eczema ☐
Sinus pressure ☐	Frequent infections ☐	Dry skin ☐
Itchy, watery, red, or dry eyes ☐	Very bad swelling ☐ Where?	Very bad itching ☐ Where?
Shortness of breath ☐	Joint swelling ☐	Fevers ☐
Chest tightness ☐	Joint pain ☐	Seizures ☐

Have you been told, or do you think your child has any of the following? Please check any that apply.

Asthma ☐	Allergic Rhinitis/Hay Fever ☐	Bowel problems ☐
Eczema ☐	Sinusitis ☐	Frequent infections ☐
Atopic dermatitis ☐	Bronchitis ☐	Thyroid problems ☐
Food allergies ☐	Angioedema ☐	Heart disease ☐
Hives (Urticaria) ☐	Nasal polyps ☐	Failure to thrive ☐
Pneumonia ☐	Ear infections ☐	Acid reflux ☐
Other medical conditions:		

When did symptoms start? ___ years ___ months ___ weeks _____ since birth

When are your child`s allergies/asthma symptoms worse?

Spring ☐ Fall ☐ Winter ☐ Summer ☐ Year round ☐

If your child has asthma and/or allergies, which of the following bring on attacks? (If not, skip this part)

Respiratory infections ☐	Being near smoke ☐	Being near dogs or cats ☐
Being near strong smells ☐	Foods ☐	Environmental allergens ☐
Weather changes ☐	Dust or dust mites ☐	Exercise, sports, playing hard ☐
Emotional upsets ☐	Other: _____	

If your child has (or you think she or he has) ASTHMA please answer below (if not, you can skip this part):

In the past month, during <u>DAYTIME</u>, how often has your child had a hard time with coughing, wheezing or breathing?
☐2 times or less than 2 times a week ☐ more than 2 times a week ☐every day ☐constantly (all of the time every day) ☐ just with illness

In the past month, during <u>NIGHTTIME</u>, how often does your child wake up or have a hard time with coughing, wheezing or breathing?
☐2 times or less than 2 times a month ☐more than 2 times a month ☐Every night ☐ just with illness

History of hospitalization because of asthma? Yes ☐ No ☐

History of being in the critical care unit? Yes ☐ No ☐ If yes, how many times? _____

History of intubation? (Putting a tube in the throat to help breath) Yes ☐ No ☐

If yes, when and for how many days? _____

History of life-threatening asthma attacks? Yes ☐ No ☐

Number of emergency room visits (life time) for asthma? _____

Number if school or work days missed during last year because of asthma:
_____

Number of asthma attacks that needed the use of oral steroids in the last year? _____

Allergies

Please list your child`s allergies below:
Medication, Food, Insect stings, other

Please describe the reaction:
(hives, swelling, breathing problems, others)

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Has your child had any previous Allergy evaluations? Yes ☐ No ☐
If yes, when and where: _____
Skin test or blood tests results: Allergic to? _____

Your Child`s Birth History

Full term ☐ Premature ☐ Vaginal ☐ Cesarean Section ☐ (if yes why):_____
Any complications at birth: _____

Nutrition

Did your child get breast milk? Yes ☐ No ☐ How many months of breast milk? _____
Name of formula/s: _____
Any feeding problems with breast milk or formula: _____
Acid reflux or eczema as a baby: _____
Any food restrictions now, including food allergies? _____
_____

Has your child had any other significant illness or hospitalizations? If so, when, where, days?

_____
_____
_____
_____
_____

Has your child had any surgeries? If so, what and when?

_____
_____
_____
_____

Family History

Please list any medical conditions (asthma, allergies, eczema, food allergy, cancer etc.)
Patient`s mother: _____
Patient`s father: _____
Patient`s siblings: _____
Patient`s grandparents: _____
_____

Social History

Where do you live? House ☐ Apartment ☐ How old? _____ Does anyone smoke? _____

Any pets at home? Please list: _____

Is there mold or mildew? Yes ☐ No ☐ **Mice?** Yes ☐ No ☐ **Cockroaches?** Yes ☐ No ☐

What kind of heating system? Radiator or baseboard ☐ Hot air ☐

Air conditioning: None ☐ Central ☐ Separate units ☐ **Humidifier or dehumidifier** (Circle)? **What kind of flooring:** hardwood ☐ area rug☐ wall to wall ☐

Wall- to- wall carpeting in the bedrooms? Yes ☐ No ☐

Do you have allergy proof: Pillow covers? Yes ☐ No ☐ **Mattress covers?** Yes ☐ No ☐

Do you have any air purifiers in your home? Yes ☐ No ☐

If yes (list rooms) _____

Hobbies/sports: _____

HLO
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MEDICATIONS THAT NEED TO BE STOPPED FOR ALLERGY TESTING

The Following is a list of Medications that you should stop taking prior to Allergy Testing. This also includes the length of time to avoid these medications.

Stop the following medications *ONE WEEK* prior to testing:

- Claritin, Claritin-D, Clarinex
- Loratadine (Generic for Claritin)
- Zyrtec (Cetirizine), Zyrtec-D, XYZAL (Levocetirizine)
- Allegra and Allegra-D
- Fexofenadine (Generic to Allegra)
- Atarax or Hydroxyzine
- Cyproheptadine or Periactin
- Tavist (Clemastine)
- Astelin Nasal Spray
- Optivar

Stop the following medications at least *3 days* prior to testing

- Zantac or Ranitidine
- Pepcid or Famotidine
- Axid or Nizatidine
- Tagamet or Cimetidine
- Bendadryl or Diphenhydramine
- Chlorpheniramine or Chlor-Trimeton
- Dimetapp
- Phenergan
- Tylenol PM
- Unisom
- All other Anti-Histamines and Decongestants

Stop the following medications *AT MIDNIGHT* the day prior to your appointment

- Accolate (Zafirlukast)
- Reglan (Metoclopramide)
- Singulair (Montelukast)
- Zyflo (Zileutin)

There are other drugs that need to be stopped for allergy testing but require your prescribing physician's approval before stopping. Your medication list will be reviewed by your allergist at your first appointment and you will be notified if you are taking any of these medications. Arrangements can then be made with the prescriber to see if you can stop the medication for allergy testing. Also, you do not need to stop antihistamines if you have chronic hives. Please call clinic at 505-272-9242 if you have any questions about which medications to stop prior to your visit.

THE FOLLOWING MEDICATIONS ARE OKAY TO USE PRIOR TO TESTING:

- ALL INHALERS FOR ASTHMA, NASAL STEROID SPRAYS AND PREDNISONE
- If the medication they take is not on the list, the patients **DO NOT** have to stop taking it.