Piedmont Pediatrics
Allergy Clinic
105 Collier Rd #4060
Atlanta, GA 30309

Patient Allergy History Questionnaire

Child's Name _____Child Goes by_____

Date of Birth _____

What is the main reason your child is being seen in the Allergy Clinic?

_____

_____

1. COUGH OR POSSIBLE ASTHMA (if none go to section 2) N/A_____

Check any of the following that are problems for your child:
□ Cough □ Wheeze □Shortness of breath □ Chest tightness
How old was your child when he/she first began having these chest symptoms?
Are there a certain times 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 □ Cold air □ Windy weather
□ Respiratory infections ("colds") □ Exercise
□Other(list)_____
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:_____ How many ICU stays_____
Has your child ever had to go to the ED 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 pneumonia? □ Yes □ No
If yes, How many episodes? ____Most Recent Episode?_____

How many school days has your child missed this school year due to these symptoms (wheeze, asthma, cough, pneumonia)?_____
How many days of work have you missed due to your child's symptoms?_____
How many nights has your child awoken from sleep because of wheezing of cough in the last 2 weeks?
_____
How many days or nights in the past 2 weeks has your child needed to use an inhaler or nebulizer to treat wheezing or cough?_____

2. NOSE OR EYE SYMPTOMS (If none go to section 3) N/A_____

Check any of the following that are problems for your child: □Runny nose □Stuffy nose □Itchy nose □Sneezing fits
□ Watery eyes □ Red eyes □Itchy eyes □Itchy ears □Itchy throat □Post nasal drip □Throat clearing
How old was your child when he/she first began having these nose/eye symptoms?_____
Which seasons are 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 the nose/eye symptoms worse: □Cats □Dogs □ Dust □Grass □ Smoke □ Fumes □ Cold air □ Other:
Has your child ever had allergy skin testing before? □ No □ Yes

If yes, check those tests were positive:	□ Dust Mite	□ Pollen	□ Mold	□ Animal Hair	□ Foods
Has your child ever been on allergy shots before?	□Yes	□No			

3. SKIN (if none go to section 4) N/A_____

How old was your child when he/she first began having eczema?_____
Check Body Parts with eczema: □Face □Scalp □Arms □Legs □Chest □Abdomen □Back
Are there any foods that seem to worsen the eczema? □Yes □No
If yes, which foods?_____
Any other skin concerns?_____

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

Food	Rash/hives/ eczema	Vomiting/ diarrhea	Facial Swelling	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 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?_____

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

Inhalers: □Flovent □Qvar □Pulmicort □Advair □Serevent □Foradil □Albuterol
□Asmonex □Other: _____
Nasal Sprays: □Nasonex □Rhinocort □Nasocort □Atrovent □Afrin
□Neosynephrine □ Dymista □ Patanase □ Azelastine
Antihistamines: □Allegra □Benadryl □Zyrtec □Atarax □Claritin □ Clarinex □ Xyzal
□ Other:_____
Skin preparations: □Hydrocortisone □Aclovate □Triamcinolone □Elocon □Elidel
□Protopic □Cutivate □Other:_____
Nebulized Medications: □Albuterol □Xoponex □Pulmicort □Atrovent
List any bad reactions your child has had to any medication:_____
_____
List all medicines your child is currently taking for any reason (include over the counter, herbal, and homeopathic remedies)_____
_____
_____
_____

ENVIRONMENT

About how old is your home? _____years
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 heater □ Steam Heat □ Forced hot air □ Wood Stove
□ Space Heater □ Central A/C □ 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_____
Check any pets that you have: □Dogs □ Cats □ Hamster □ Guinea Pig
□ Other_____ □ Pets in Bed □ Pets in Bedroom
Do any of your child's caretakers smoke: □ No □ Yes (Who?)_____
Where does your child sleep: □ Own bed □ with sib or parent □ Other (such as sofa)

ENVIRONMENT (con't)

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 daycare environment (please describe) _____

FAMILY HISTORY (Check all that apply) :

Relative	Asthma	Nasal allergy	Eczema	Food allergy	Hives	Allergy Shots
Mother						
Father						
Brother or sister						

List other diseases that run in the family:_____

_____

_____

PAST HISTORY

List by date any hospitalizations for problems other than asthma:_____

List any surgeries and dates:_____

List your child's birth weight: _____

Was your child premature? □No □Yes

List any newborn problems:_____

REVIEW OF SYSTEMS

Skin: Has your child had hives? □Yes □No

If yes, how many days did the hives last?_____

_____

HEENT:

How many ear infections has your child had in the last year?_____

How many sinus infections has your child had in the last year?_____

Has your child had PE (ear) tubes placed? □Yes □No

Does your child have difficulty swallowing, pain with swallowing, or heartburn? □Yes □No

Heart:

Has your child ever had a heart murmur or irregular heartbeat? □Yes □No

Has your child ever fainted or passed out? □Yes □No

GI tract:

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 including ADHD: _____

Kidneys: Does your child have any kidney problems? □Yes □No

To the best of my knowledge, the information provided here is correct:

_____ _____

Parent/Guardian Provider

Date_____ Date_____

Time_____ Time_____