Mount Sinai School of Medicine
Division of Pediatric Allergy & Immunology

Patient Name: _____ **Birthdate:** _____

Address: _____

Phone #: (____) _____ **Parent Name:** _____

Please answer all the questions as completely as possible so that we may obtain current and complete information about your child.

Allergy History: (Please check Yes or No, and answer the questions)

1. **What is the reason for this consultation?** _____

2. **Please give the name and address of the Physician requesting this consultation:** _____

   _____

3. **Please give additional names to whom the correspondence should be addressed (plus phone number):** _____

   _____

4. **Has your child been previously evaluated for allergies, and if yes, by whom and when?**

   No _____ **Yes** _____ (Please list the doctor's name, address, phone number): _____

   _____

5. **Please indicate which diagnoses have been made about your child:**

   _____ Asthma _____ Allergic cough _____ Bronchitis

   _____ Other pulmonary diseases _____ Allergic rhinitis (hayfever) _____ Allergic conjunctivitis

   _____ Urticaria (hives/welts) _____ Eczema _____ Oral Allergy Syndrome

   _____ Food allergies (list foods): _____

   _____ Medication/Drug allergy (list medications): _____

   _____ Latex allergy _____ Insect venom allergy _____ Sinusitis

   _____ Recurrent infections _____ Immune disorders

   _____ Other (please list): _____

6. **Has your child been skin tested before? No_____ Yes _____, and if yes, when?**_____

   What were the results? _____

   _____

   Has your child had blood test for allergy before? No _____ Yes _____, and if yes, when? _____

   What were the results? _____

7. **Has your child received allergy shot treatments before? No _____ Yes _____, and if yes, when?_____**

_____ Where? _____

For what allergies? _____

8. **How many days of school or work have been missed by your child due to allergies or illness in the past year?** _____

Medications:

1. **Please list all medications your child is taking (include dose and times):**

_____

_____

2. **Please list other previous medications your child has taken that were helpful:**

_____

_____

3. **Please list any other medications that were of no help:**

_____

_____

Prenatal History: (Birth History) Please complete the following:

1. **Length of pregnancy (gestation):** ___weeks.

Were there any problems with the delivery? _____ No _____ Yes. If yes, please list: _____

_____

2. **Is your child the product of a Caesarian Section?** _____ No _____Yes

3. **Infant's birth weight:** _____ pounds, _____ ozs. **Birth length:** _____ inches.

4. **How long was the baby exclusively breastfed?** _____

5. **Maternal restrictions while breast-feeding?** _____ No _____ Yes. If yes, please list foods that were avoided: _____

6. **At what age was formula introduced?** _____

7. **What formula was first given?** _____

8. **Explain any adverse reactions to formula or reasons for formula changes:** _____

_____

_____

9. **At what age were solid foods first introduced?** _____

10. List foods in the order in which they were introduced and list any symptoms if these foods were problematic:

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Childhood Illnesses (Please indicate the date that your child had any of the following illnesses):

Croup _____ Bronchiolitis _____ Bronchitis_____ Pneumonia _____

Other medical problems: _____

Has your child had any surgeries or hospitalizations? _____ No _____ Yes. If yes, please describe:

_____

_____

Immunizations:

Are your child's immunizations up to date? _____ Yes _____ No. If no, explain why: _____

_____

Please list any adverse reactions to any immunizations: _____

Did your child receive the influenza (flu) immunization last fall/winter? _____ No _____ Yes

Family History (Please use the following abbreviations to indicate these illnesses in your family):

Asthma - A | Allergic rhinitis (hayfever) - AR | Atopic dermatitis - AD | Sinusitis - S
Urticaria (hives) -U | Repeated infections - I | Migraines - M | Food Allergy - FA (Please list foods)

1. Immediate family **Age** **Illnesses** **Age** **Illnesses**

Mother ____ _____ Father _____ _____

Siblings:

Name	Male	Female	Illnesses
1. _____	____	____	_____
2. _____	____	____	_____
3. _____	____	____	_____
4. _____	____	____	_____

2. Extended family

	Mother's side	Father's side
Grandmother	_____	_____
Grandfather	_____	_____

Are there any other major medical problems in your family (diabetes, heart, lupus, thyroid, immunodeficiency, cancer, or other): _____

_____

Foods

1. **Has a physician ever told you that your child has food allergies?** _____ No _____ Yes.
   If yes, list the foods:

   _____

   _____

2. **What kind of testing was done to determine these food allergies?** RAST (blood test)____, Skin testing _____, other _____ and when was this testing done? _____

3. **If your child has allergic reactions after eating certain foods or medications, please list the amount ingested, time between ingestion and onset of symptoms, nature of the symptoms and their duration.**

   1. _____
   2. _____
   3. _____
   4. _____
   5. _____

4. Does your child complain of itching in his/her mouth after eating raw fruits or vegetables? _____

   If yes, please list fruits/vegetables and the age of onset: _____

5. **Has a special diet been tried?** _____ No _____ Yes. (If yes, briefly describe the diet, how long your child was on the diet, how well the diet was maintained, and if the diet was helpful.)

   _____

   _____

6. **While following a special diet, did your child have "accidental ingestion" of any of the foods being avoided?** _____ No _____ Yes. (If yes, please describe any adverse reactions):

   _____

   _____

7. **Is the child in Daycare** _____ **Pre-Kindergarten** _____ **School?** _____

   Does your child eat meals provided by Daycare, Pre-Kindergarten, or School? ___ No ___Yes
   Are there any pet animals in the Daycare, Pre-Kindergarten, or School? ___ No ___Yes
   If yes, what? _____

Environmental Survey

1. **How old is your home?** _____ **years.**

2. **How long have you lived there?** _____ **years. Briefly describe the type of house (brick, wood, apartment)**

   _____

3. **Is there a basement in your home?** ___ No ___ Yes

4. **Is the mattress in your child's bedroom enclosed in plastic or covered with a special impermeable enclosure?** _____ No _____ Yes

Is the pillow(s) encased as well? _____ No _____ Yes

5. **What type of air conditioning system do you have in your home?**

None Ceiling fans Window unit Central air with vent Other: _____

6. **What type of heating system do you have in your home?**

Wood burning stove Central heat with vent Gas heat Coal Steam radiator

Electric heat (forced air) Electric radiator Other:

7. **Are there any smokers in the home?** _____ No _____ Yes

Is the child exposed to cigarette smoke in the family/friend's home? _____ No _____ Yes

8. **Is a humidifier used in the home or the child's bedroom?** No _____ Yes _____

9. **Are there houseplants in the home?** No _____ Yes _____

10. **Does your child have allergic symptoms after exposure to animals?** No ____ Yes _____

If yes, what type of symptoms? (Circle the choices)

Eyes:	itchy	watery	runny	swollen
Nose:	itchy	runny	stuffy	sneezing
Chest:	tight	wheezing	coughs	shortness of breath
Skin:	itchy	hives	eczema	rashes

11. **Do you have pets?** ____ No ____ Yes **Is the pet a house pet?** ____ No ____ Yes

Does the pet sleep in the child's room? ____ No ____ Yes / If yes, what type of animal _____

12. **Is your child exposed to animals at school or a friend's home?** _____ No _____ Yes

13. **Have you seen any pests in your home in the past 30 days? (Circle the choices)**

Cockroaches Mice Rats

14. **Does your child have allergic symptoms during certain seasons of the year?** _____ No _____ Yes

If yes, which season(s) and what type of symptoms? (Please list symptoms)

Spring _____

Summer _____

Fall _____

Winter _____

15. Does your child have allergic symptoms after exposure to these? (Circle yes or no)

Raking leaves	Yes	No	Barnes	Yes	No
Damp Basements	Yes	No	Cutting grass	Yes	No

If yes, what type of symptoms? (Circle the choices)

Itchy eyes Runny nose Watery eyes Nasal congestion

Sneezing Skin rashes other: _____

Medication Allergy

1. Has your child ever had an adverse reaction to any medications? _____ No _____Yes

Name of the medication _____
Please describe the reaction _____

_____

Insect Bites

1. Has your child ever had an unusual reaction to an insect sting or bite? No_____ Yes _____
If yes, what type of reaction and symptoms? (Was the reaction life threatening or require medical intervention?) _____

_____

_____

2. What kind of insect? (If identifiable) _____

Comments

Are there any other issues you would like to discuss?

_____

_____

_____

_____

_____

Thank you for your time in answering all the questions as completely as possible. Please fax, mail, or bring the questionnaire with you to your appointment. Please call if you have any questions or concerns: Mount Sinai Hospital Division of Pediatric Allergy, (212) 241-5548.

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