Icahn School of Medicine at Mount Sinai

Department of Pediatrics
Division of Allergy & Immunology

Jaffe Food Allergy Institute
One Gustave L. Levy Place, Box 1198
New York, NY 10029-6574
T 212-241-5548
F 212-426-1902

Hugh A. Sampson, MD
Director

Scott H. Sicherer, MD
Division Chief

Anna Nowak-Wegrzyn, MD

Julie Wang, MD

Supinda Bunyavanich, MD, MPH

Jacob Kattan, MD

Niti Chokshi, MD

Location: **5 East 98th Street,** (between 5th and Madison Avenue), **10th floor**
Please **arrive 15 minutes early** to complete the registration process.
We ask that you plan your day to ensure adequate time to remain at the clinic **for 2-3 hours**.

PRIOR TO YOUR VISIT

Please **complete the attached QUESTIONNAIRE** and collect pertinent medical records and/or test results.

Please have your child **STOP** antihistamine medications (also found in over-the-counter remedies for allergy and cold symptoms) as follows: *If you are unsure as to whether a medication is an antihistamine, please check with your pharmacist.*

- 04 days prior to visit = Benadryl, diphenhydramine, chlorpheniramine, brompheniramine
- 07 days prior to visit = Zyrtec, claritin, allegra, clarinex, hydroxyzine, atarax, rynatan, vistaril
- 10 days prior to visit = Doxepin, Periactin

If you cannot discontinue antihistamines or inadvertently took them,
we advise that you still KEEP YOUR APPOINTMENT.

Do **NOT** stop antibiotics (such as Amoxicillin, Zithromax), asthma medications (such as Singulair, Flovent), or steroid nose sprays (such as Flonase, Nasonex). These should be continued.

ON THE DAY OF YOUR VISIT

Mount Sinai is a teaching hospital which means your visit may begin with your initial Care Provider being your physician's associate, fellow and/or nurse.

If you are more than 20 minutes late for your appointment, we cannot guarantee that you will be seen due to the large volume of patients.

Parking your car will require extra time. The parking garage is located at 99th Street between Park and Madison Avenues. Metered parking around Mount Sinai and the vicinity is also available although limited. Thus, please plan accordingly.

Upon arrival, please have ready upon check-in:

1. Completed questionnaire
2. Pertinent medical records and test results
3. Insurance card
4. HMO/PPO authorization/referral form(s) if necessary
5. Name, address and phone number of your referring physician and/or pediatrician.

NOTE: There is a $50.00 re-booking fee for missed appointments or cancellations made without 24 hours notice.

Please be advised that if you cancel your appointment, the next available appointment may be several months away.

MOUNT SINAI SCHOOL OF MEDICINE PEDIATRIC ALLERGY AND IMMUNOLOGY

Thank you for your time in answering all questions as completely as possible.
We look forward to meeting you and your family.

First Name: _____ Last Name: _____ Date of Birth: _____

Referring and/or Primary Care Provider (PCP): _____

Street: _____ City_____ State_____ Zip Code_____

Phone Number: _____ Fax Number: _____

Reason for today's visit: _____

What specific questions/concerns are most important to address at today's visit? :

_____
_____
_____
_____

Current Medications: _____**None (Please Skip to Next Section)**

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

Name of medication	Dose	Frequency

Food Allergy History: _____**None (Please Skip to Next Section)**

What foods are currently excluded from your child's diet? _____
_____

Which of these foods, if any, are not strictly excluded (e.g. has small amounts of an ingredient?) _____
_____

If your child has had an allergic reaction after eating certain foods, please list:

Food	Date or age of child at reaction	Amount of food	Type of exposure (ie. ingestion, contact, injection)	Symptoms

YES NO Has your child been **skin** tested for food allergy before? ***If YES, please bring test results***
YES NO Has your child had **blood** tested for food allergy before? ***If YES, please bring test results***

Please list foods avoided purely on the basis of previous testing or advice (for example, there has never been a reaction or ingestion):_____ _
_____

YES NO Does your child complain of itching in the mouth after eating raw fruits or vegetables?
If yes, please list the fruits or vegetables: _____ _
_____ _

Eczema/Atopic Dermatitis History: _____None (Please Skip to Next Section)

What are triggers for eczema flares? _____ _
_____ _

How often does your child take a bath/shower? _____ _
How long is the bath/shower? _____
What soap/cleanser do you use? _____
What moisturizer do you use? _____

What medications (topical or oral) have been helpful?_____ _
_____ _

What medications have not been helpful? _____
_____

Has the skin ever been infected, requiring oral antibiotics? _____

Environmental Allergy History: ____None (Please Skip to Next Section)

YES NO Does your child have allergic symptoms during certain seasons?
If yes, which season(s) and what type of symptoms?

Spring:	Summer:
Fall:	Winter:

YES NO Does your child have allergic symptoms after exposure to animals?
If yes, which animal and what type of symptoms? _____
_____

YES NO Has your child had skin or blood testing for environmental allergies before?
*****If YES, please bring test results*****

YES NO Has your child had a suspected allergic reaction to insect stings?
If yes, please specify: _____

YES NO Has your child received allergy shots before?
If yes, when and for how long?_____

Asthma/Wheeze/Cough History: **____ None (Please Skip to Next Section)**

The following questions address symptoms of cough, wheeze, shortness of breath, etc.

Please Circle how often these occur:

1. How often does your child experience symptoms?	2 times a week or less	More than 2 times a week	Everyday	Several times a day
2. How often does your child wake up from sleep due to symptoms?	2 times a month or less	3-4 times a month	More than once a week	Every night
3. How frequently does your child use Albuterol and/or Xopenex?	2 days a week or less	More than 2 days a week	Everyday	Several times a day
4. Does asthma cause any limitation with activity?	None	Minor	Some	Very limited
5. How many times per year does your child have exacerbations?	0-1 times a year	2 times a year	3 times a year	More than 3 times a year

What medications for asthma/cough/wheeze is your child taking? _____
_____

How many times has your child needed oral steroids (ie, Orapred, prednisone) for respiratory symptoms in the past 12 months? _____

YES NO Has your child ever been hospitalized for respiratory symptoms?

YES NO If yes, has your child ever been in the intensive care unit (ICU?)

Drug Allergy History: **____None (Please Skip to Next Section)**

If your child has had allergic reactions after taking certain medication, please list:

Drug name	Date of reaction (or age of child)	Type of exposure (oral, injection)	Symptoms

Surgical History: (please circle Yes or No) **_____None (Please Skip to Next Section)**

YES NO Adenoidectomy
YES NO Ear Tubes
YES NO Sinus Surgery
YES NO Tonsillectomy
Other: _____

Family History: **_____None (Please Skip to Next Section)**

	Food Allergy**	Eczema/ atopic derm	Allergic Rhinitis	Asthma	Eosinophilic esophagitis	Bee/venom sting allergy	Immune deficiency	Lupus/other rheumatologic disease	Repeated Infections	Thyroid disease	Sinusitis	Other
Mother												
Father												
Sister												
Brother												
Other_____												

**If a member of the family has food allergies, please specify foods and symptoms: _____ _
_____ _
_____ _

Social History: (Please Circle Yes or No)

YES NO Does the child attend daycare?
YES NO Does the child attend school? If yes, what grade? _____

Environmental History: (Please Circle Yes or No)

YES NO Is your child's mattress covered with a special impermeable enclosure?
YES NO Is /are pillow(s) covered as well?

Pets: (Please Circle Yes or No)

YES NO Do you have any Pets? If yes, what type of pet(s)? _____
YES NO Is the pet a house pet?
YES NO Does the pet sleep in the child's room?

Pest infestation: (Please Circle Yes or No)

YES NO Mice
YES NO Rats
YES NO Cockroaches
YES NO Termites

Other: (Please Circle Yes or No)

YES NO Tobacco smoke exposure in home?
YES NO Tobacco smoke exposure in family/friend home?

Immunizations: (Please Circle Yes or No)

YES NO Are your child's immunizations up to date?
YES NO Have there been any adverse reaction(s) to immunizations?
If yes, please explain: _____

Reviewed and confirmed by Allergy and Immunology Attending

Dr. _____ Date: _____