KAISER PERMANENTE ®

The Permanente Medical Group, Inc.

PEDIATRIC ALLERGY, ASTHMA & IMMUNOLOGY QUESTIONNAIRE

Name: _____ MR#: _____ Age _____ Date _____

Home phone: _____ Work phone: _____ Cell phone: _____

Occupation: _____ Referred by: _____

Which **allergy** symptoms bother you the most? _____

How long have you lived in the Bay Area? _____ Present address? _____List the places you have lived for more than 2 years. _____

CURRENT SYMPTOMS AND COMPLAINTS* – *PLEASE CHECK (√) ALL THAT APPLY

CHEST	NOSE	EARS	EYES	THROAT	SKIN
__ Asthma __ Cough __ Wheeze __ Tightness __ Shortness of Breath	__ Itching __ Congestion __ Sneezing __ Running	__ Itching __ Blockage	__ Itching __ Tearing	__Itch/Tickle __ Hoarseness __ Post Nasal Drip	__ Dry Skin __ Hives __ Rash

-**Are you worse with** __Dust/Dust mite __ Animals __ Mold/Mildew __ Pollen __ Exercise __Odors/Scents __Respiratory Infections __ Smoke/Fireplace __ Indoors __Outdoors __Other

-**Are you better with** __ Indoors __ Outdoors __ Vacations __ Exercise __ Medications

- When did your symptoms begin? _____
- When are your symptoms present? __Year-long __ Seasonal __ Other_____
- Severity of your symptoms on a scale of 0 -10? (**0 is normal, 10 is very severe**) _____

OTHER ALLERGY PROBLEMS

Please describe any medication allergies _____

Please describe any severe food allergies (such as anaphylaxis, wheezing, shortness of breath, hives):

_____

Have you had a reaction with rubber/latex i.e. pacifier, gloves, balloons, condoms, diaphragm? __ No __ Yes

Have you had a severe reaction to a bee, wasp, or hornet sting? __ No __ Yes

ASTHMA: How many times have you: been to the emergency room or urgent care in the past year? _____

taken prednisone/cortisone "burst" in the past year? _____ been hospitalized? _____ been in the ICU? _____

PAST MEDICAL HISTORY

__ Nasal Polyps __ Lung Problem __ Mental Health Disorder

__ Heart Disease __ Neurologic Problem __ Heartburn/ Hiatal Hernia

__ Has anyone ever said you stopped breathing while sleeping?

Please describe any other medical problems: _____

_____

- Any problems with pregnancy or delivery? _____
- At birth: Weight _____ ___Prematurity ____Breathing problems __ Other _____
- If breastfed, how long? _____ Formula type/changes? _____
- In the first year of life? __colic after 4 months ___Eczema _Chest congestion __Repeated colds __ Ear infections

***Hospital/surgery/Emergency Department visits**:* _____

_____

FAMILY HISTORY: List relatives with nasal allergies, asthma, food allergy, eczema OR other allergic disease

_____

SOCIAL HISTORY:

- Living arrangement: ___ 2 Parents __1 Parent ___Divorce/separation-custody __Other_____
- Please list your hobbies: _____
- Parent's occupation/s: _____
- Grade level _____ School _____
- Any school problems? _____
- Other information _____

ENVIRONMENTAL EXPOSURE __ Apartment __ Flat __ House __ Condo __ In-law Apt __ Other _____

Pillow	Blanket	Mattress	Flooring	Windows	Animals
__ Synthetic __ Feather __ Foam/Rubber	__ Down __ Wool __ Synthetic __ Cotton __ _____	__ On Frame __ Standard Mattress __ Box Spring __ Futon __ Foam rubber __ Crib	__ Wall-to-Wall Carpeting __ Area Rug __ No Carpeting __ _____	__ Blinds __ Shades __ Curtains __ Drapes __ _____	__ Cat #___ __ Dog #___ __ ____ #___

Other	Heating
__ Roof Leak __ Roaches __ Open Bookcases __ Stuffed Animals __ Mold __ Clutter __ Plants	__ Central Heat __ Wall/Space Heater __ Fireplace in BR __ Bedroom Vent

CURRENT MEDICATIONS: Please list all medications including topical, vitamins and herbal supplements

REVIEW OF SYSTEMS

__ Unexpected weight loss	__ Leg swelling	__ Loss of consciousness
__ Blurred Vision	__ Vomiting	__ Hallucinations
__ Nosebleeds	__ Change in urinary habits	__ Bleeding problems
__ Coughing up blood	__ Falls	__ Excessive thirst