ENT Allergy Associates
Allergy, Asthma & Immunology
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Allergy Survey/ Medical History

Appointment Date: ___________________

Child's name: _________________________________ Date of birth: ___________________ Age: _____

Parent's names: ________________________________ Phone: ________________________

Home Address: ____

Name of child's doctor: ____

1. Allergy history:
   A. Briefly state your child's problem: ____

   B. Describe typical symptoms: ____

   ____

   C. Date or age of onset: ____

   D. What factors do you think may bring on worsening? (Check those that apply)

   ___Foods ___Odors; cosmetics ___Animals ___House dust
   ___Drugs ___Exertion (exercise) ___Leaves ___Tree pollen
   ___Smoke ___Temp. Changes ___Fumes ___Other
   ___Infections ___Dampness or rain

   E. When are the symptoms more severe?

   ___Fall ___Night ___Home (indoors) ___Other places _______________
   ___Winter ___Day ___Home (outdoors)
   ___Spring _____ ___School
   ___Summer

   F. How many school or day care days has your child missed in the past year? ________________

   G. Has your child been evaluated by an allergist in the past? ___Yes ___No

   H. List known allergies: ____

   Medicine Allergy, including antibiotics: ____

   Food Allergy:____

   Insect Allergy:____

2. Medications:

1. Antihistamines (Zyrtec, Allegra, Claritin, Benadryl): ____________________________________
2. Decongestants (Sudafed, Entex): ____
3. Antibiotics: ____
4. Wheezing medicine (bronchodilators): ____
5. Steroids (prednisone, Decadron): ____
6. Sprays, mists, nose drops: ____
7. Allergy injections: ____
8. Gamma globulin: ____
9. Other: ____
10. List any medicine your child takes for other conditions: ________________________________

____

3. Child's past medical history:

A. Birth Weight: ____________ Gestational age in weeks:___________

Complications: ____

B. Illnesses: (Yes, No, Frequency, Ages occurred)

Ear infections: ____

Tonsillitis: ____

Colds: ____

Sinusitis: ____

Bronchitis: ____

Pneumonia: ____

Skin rashes (other than diaper rash or "heat rash"): ____________________________________

Thrush: ____

C. Hospitalizations: (Where, When, for what reason?)

____

____

D. Surgery: ____

E. Immunizations: Up-to-date for age? ___Yes ___No

F. Other health problems: ____

____

4. Feeding history:

Formula taken by your child: ____

What foods (if any) do you not feed your child? _______________________________________

Why? ____

5. Environment: (Check or circle appropriate selection)

With whom does the child live? ____

A. ___House (years old) ___Mobile Home (years old) ___Apartment (years old)

B. Heating: ___Central ___gas ___electric ___space heaters ___steam heat

C. Air Conditioning: ___Central ___Window units

D. Humidifier: ___Room ___central Air filter: ___Room ___central

E. Ceiling fans: (Which rooms) ____

F. Floors: Living areas: ___Carpet ___Wood ___Tile ___Concrete
Patient's Bedroom: ___Carpet ___Wood ___Tile ___Concrete
Type of mattress: ___regular ___feather ___crib ___other
Type of pillows: ___polyester ___foam ___feather ___other
Are there allergy/plastic covers on the mattress? ___Yes ___No
Pillow encasings? ___Yes ___No
Type of blankets: ___Cotton ___polyester ___wool ___Down ___Other __________
Type of curtains and bedspreads: ____
Are there stuffed toys in the room? ___Yes ___No
Any stuffed toys in the bed? ___Yes ___No

G. Animal contact (type of animals, how many):

Inside your home: ____
Outside your home: ____
Relative or friend's home: ____

H. What surrounds your home? ___other homes/neighborhood ___fields ___factory
___other ____________________

I. Is mold or mildew (smell or dampness) a problem in your home? ___Yes ___No
Any water leaks? ___Yes ___No If so, where? _________________________________

J. Does your child attend a day care center, preschool or Headstart? ___Yes ___No

If so, how many days per week? ________; hours per day ________.
Approximately how many other children also attend the day care center? _________

K. Do any smokers live in the home? ___Yes ___No Whom? ___________
Do they smoke inside the home? ___Yes ___No
In the car? ___Yes ___No

L. Fireplace/woodstove used: ___Yes ___NO

6. Family history:

Do any members of the immediate family have any significant health problems? _____________________

____

How many brothers are there? (Ages) ________________ How many sisters? (Ages)________________

Please Check All That Apply

	MOTHER	FATHER	BROTHER/SISTER	OTHER
ASTHMA				
CHILDHOOD ASTHMA				
HAY FEVER				
ECZEMA				
FOOD ALLERGIES				
DRUG ALLERGIES				
REPEATED INFECTION				
OTHER				