Pediatric Specialists of Virginia

Children's National INOVA

Department of Allergy and Immunology
New Patient Questionnaire

Please fill this form out and bring it to your appointment

Child's Name: _____

Your name and relationship to child: _____

Briefly explain what problems your child has been having and when they started: _____

_____

_____

Primary Symptoms are worse with:

☐ Spring	☐ Summer	☐ Fall	☐ Winter	☐ All year
☐ School days	☐ Home	☐ Vacations		
☐ Weather change	☐ Indoors	☐ Outdoors		
☐ Humidity	☐ Heat	☐ Cold Air	☐ Windy Days	
☐ Tobacco smoke	☐ Perfumes	☐ Irritants	☐ Flowers	
☐ Cats	☐ Dogs	☐ Horses	☐ Other pets:	
☐ Moldy/musty areas	☐ Dust	☐ Stuffed animals	☐ Emotion or stress	

SYMPTOMS: Please check all that apply:

Eyes:	☐ Itching	☐ Redness	☐ Watering	
Nose:	☐ Congestion	☐ Runny	☐ Sneezing	☐ Itching
	☐ Nose rubbing	☐ Post nasal drip		
Throat:	☐ Throat clearing			
Skin:	☐ Eczema	☐ Atopic dermatitis	☐ Hives:	☐ Now ☐ Past
	☐ Contact dermatitis	☐ Poison ivy		
Cough:	☐ Waking up in the AM	☐ Throughout the day	☐ Awakened at night	☐ With exercise
	☐ Dry	☐ Produces sputum		
	☐ Everyday	☐ 2x or more per week	☐ Once a week	☐ Once a month

Patient Identification

If label is not available, please complete:

Patient Name _____

DOB: _____ MR# _____

Office Use Only

I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

___It was emergency treatment
___I could not communicate with the patient
___The patient refused to sign
___The patient was unable to sign because
___Other (please describe)

Signature _____

SYMPTOMS: Please check all that apply:				
Shortness of breath	☐ Awakened at night	☐ While resting	☐ With exercise	
	☐ Age of onset: _____		☐ Relieved by: _____	
Wheezing/chest tightness	☐ Awakened at night			
	☐ Every day	☐ 2x or more a week	☐ Once a week	☐ Once a month
	☐ Relieved by: _____			
Asthma	☐ Ever Diagnosed?	☐ Oral steroids for asthma	☐ ER visits for asthma	☐ Hospitalized for asthma
	☐ Admitted to ICU for asthma			
Other	☐ Snoring	☐ Mouth breathing	☐ Apnea	

Recurrent and Chronic Infections:		
☐ Frequent sinus infections	☐ How many per year: _____	☐ Sinus surgery/when: _____
☐ Frequent ear infections	☐ How many per year: _____	☐ Ear tubes places/when: _____
☐ Pneumonia	☐ X-ray did show pneumonia	☐ Bone or joint infections
☐ Abscesses of skin, frequent skin infections , or abscesses of internal organs		

Has your child ever been seen by an Allergist? ☐ Yes ☐ No If yes, when? _____

Name of the Allergist? _____

Has your child ever had the following tests? If so, **when** and what were the **results**?

Test	When	Result
☐ Allergy skin testing	_____	_____
☐ Allergy blood test (RAST)	_____	_____
☐ Chest or sinus x-ray	_____	_____
☐ Immune system test	_____	_____

Has your child ever had an allergic reaction to any foods? ☐ Yes ☐ No If yes, which ones?

Food (list)	Reaction (describe)	Date last eaten
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____

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Has your child ever had a reaction to an insect sting? _____

Please list your child's past medical history: _____

- Surgical History: Please circle all that apply

  ☐ Adenoids ☐ Tonsils ☐ Ear Tubes ☐ Sinus Surgery ☐ Other: _____

Are your child's immunizations up to date? ☐ Yes ☐ No

What medicines is your child currently taking? _____

_____

Does your child take any other supplements, including multivitamins, herbal or alternative medications? ☐ Yes ☐ No

If yes, which ones? _____

_____

Has your child ever had a reaction to any medications? ☐ Yes ☐ No If yes, which ones?

Medication (list)	Reaction (describe)	Date last taken
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____

Home Environment:				
Home	☐ Single Family Home	☐ Townhouse	☐ Apartment or Condo	☐ Trailer
	Number of years you have lived in home? _____			
	Age of home? _____			
	☐ In a woody place?	☐ Smoker in the home?		
	Previous owners had:	☐ Dog	☐ Cat	
	Bath soap: _____	Shampoo: _____	Laundry soap: _____	☐ Dryer sheets used
Heat/Air Conditioning	☐ Forced Air Heat	☐ Central A/C	☐ Window A/C	☐ Filter changed regularly
Flooring	☐ Mostly wall to wall carpet		☐ Mostly hard surface flooring (wood, tile, linoleum, etc.)	
Pets	☐ Dog	☐ Cat	☐ Birds	☐ Hamster/ Gerbil
Pests	☐ Mice	☐ Cockroaches	☐ Mold	

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Child's Room	☐ Carpet	☐ Area Rug	☐ Blinds	☐ Curtains
	☐ Humidifier	☐ HEPA filter		
	☐ Stuffed animals	☐ Stuffed animals in bed	☐ Stuffed animals washed regularly	
	☐ Dog enters bedroom	☐ Dog sleeps on bed	☐ Cat enters bedroom	☐ Cat sleeps on bed
	☐ Regular mattress	☐ Feather pillow		
	☐ Dust mite covers on:	☐ Pillow	☐ Mattress	☐ Box springs

Family History	Mother	Father	Siblings
Asthma	☐	☐	☐
Eczema	☐	☐	☐
Allergies/Hay fever	☐	☐	☐
Food Allergy	☐	☐	☐
Medication Allergy	☐	☐	☐
Immunodeficiency	☐	☐	☐

For food allergies, please list the specific foods to which the family member is allergic:

_____

Father's Occupation: _____

Mother's Occupation: _____

Does the child attend daycare? ☐ Yes ☐ No

If yes: How many other children are at the daycare? _____

Are there any pets at the daycare? _____

Is there carpeting at the daycare? _____

Are there any environmental concerns at the daycare? _____

_____

Thank you! We look forward to meeting you!

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