Patient Name: ________________________________ **DOB:** ___/___/______

Allergy/Immunology
Child/Teen New Patient - Health History Questionnaire

Medication Allergies

List all known medication allergies OR check ☐ if there are no known drug allergies

Medication	Reaction	Date (approx.)
1. ______________________	______________	__________
2. ______________________	______________	__________
3. ______________________	______________	__________
4. ______________________	______________	__________

Current Medications

List all current medications. Include prescribed and over the counter drugs, including vitamins.
Include medications taken every day and medications taken only when needed.

Medication	Dosage	Frequency	Start Date (approx.)
1. ______________________	_____	__________	__________
2. ______________________	_____	__________	__________
3. ______________________	_____	__________	__________
4. ______________________	_____	__________	__________
5. ______________________	_____	__________	__________
6. ______________________	_____	__________	__________

Vaccines

Are vaccines up to date? (Circle one) Yes No

Provide most recent dates for these vaccines:

Vaccine	Date
☐ Influenza	Date received (approx.) ____ / ____
☐ Pneumococcal conjugate, PCV 13	Date received (approx.) ____ / ____
☐ Pneumococcal polysaccharide, PPV 23	Date received (approx.) ____ / ____
☐ Td (tetanus, diptheria)	Date received (approx.) ____ / ____
☐ Tdap (tetanus, diptheria, pertussis)	Date received (approx.) ____ / ____
☐ Hib (Haemophilus influenzae Type B)	Date received (approx.) ____ / ____

Past Surgical History:

Check all surgeries that apply OR check ☐ if there are no previous surgeries

- ☐ Adenoidectomy
- ☐ Appendectomy
- ☐ Back/Spine Surgery
- ☐ Balloon Sinuplasty
- ☐ Bronchoscopy
- ☐ Cardiac (Heart) Surgery
- ☐ Cholecystectomy (Gallbladder)
- ☐ Colonoscopy
- ☐ Dermatologic (Skin) Surgery
- ☐ Gastrointestinal Surgery
- ☐ Genitourinary Surgery
- ☐ Gynocologic Surgery
- ☐ Laparoscopy
- ☐ Laparotomy
- ☐ Oncologic/Cancer Surgery
- ☐ Plastic/Reconstructive Surgery
- ☐ Pulmonary (Lung) Surgery
- ☐ Septoplasty
- ☐ Sinus Osteotomy
- ☐ Sinus Surgery
- ☐ Thyroid Surgery
- ☐ Tonsillectomy
- ☐ Tonsillectomy/Adenoidectomy
- ☐ Turbinate Reduction
- ☐ Tympanostomy- Ear tubes
- ☐ Vascular Surgery
- ☐ Other: ____________________
- ☐ Other: ____________________
- ☐ Other: ____________________
- ☐ Other: ____________________

Past Medical History

Check all diseases and conditions that apply OR check ☐ if there are no previous diseases or conditions

- ☐ ADHD
- ☐ Anemia
- ☐ Anesthesia Complications
- ☐ Allergy- allergic conjunctivitis
- ☐ Allergy- contact dermatitis
- ☐ Allergy- environmental
- ☐ Allergy- food
- ☐ Allergy- latex
- ☐ Allergy- stinging insects
- ☐ Anaphylaxis
- ☐ Angioedema (swelling)
- ☐ Are you pregnant/planning pregnancy?
- ☐ Arthritis
- ☐ Asthma
- ☐ Autoimmune disease
- ☐ Blood clots/DVT/Pulmonary Embolism
- ☐ Breastfeeding/Nursing
- ☐ Bronchitis
- ☐ Cancer
- ☐ Cardiovascular Disease (heart disease)
- ☐ Cholelithiasis (Gallstones)
- ☐ Chronic ear infections
- ☐ Congenital Disorder
- ☐ Cystic Fibrosis
- ☐ Developmental or Behavioral Disorders
- ☐ Diabetes Mellitus
- ☐ Ear or Hearing Disorders
- ☐ Eczema
- ☐ Emphysema or COPD
- ☐ Endocrine Disorder
- ☐ Eosinophilic Esophagitis/Gastritis/Colitis
- ☐ Fibromyalgia
- ☐ Gastrointestinal Disease
- ☐ Genetic/Hereditary Disorder
- ☐ HIV or AIDS
- ☐ Hematologic (blood) Disease
- ☐ Hypercholesterolemia (high cholesterol)
- ☐ Hypertenstion (high blood pressure)
- ☐ IBS (irritable bowel syndrome)
- ☐ Immunologic Disease
- ☐ Insomnia
- ☐ Meniere's Disease
- ☐ Mental Illness
- ☐ Migraines
- ☐ Mood Disorder (depression, anxiety)
- ☐ Musculoskeletal Disease
- ☐ Nasal polyps
- ☐ Neurologic Disorder
- ☐ Obesity
- ☐ Osteopenia/Osteoporosis
- ☐ Pneumonia
- ☐ Pulmonary (lung) Disease
- ☐ Reflux/GERD (heartburn)
- ☐ Renal (kidney) Disease
- ☐ Sinusitis
- ☐ Sleep Apnea
- ☐ Thyroid Disease
- ☐ Tobacco Use
- ☐ Urologic Disorder
- ☐ Urticaria (hives)
- ☐ Vertigo
- ☐ Vision/Eye Disorder
- ☐ Vitamin Deficiency

Social History

Circle your answer(s) or fill in blanks.

Smoking Status: Never Smoker Former smoker Current every day smoker Current some day smoker

Currently Smoking: None 1 PPW 2 PPW 1/4 PPD 1/2 PPD 1PPD 1.5 PPD 2 PPD 3+ PPD

Tobacco - years of use: ________

Parents' marital status: Married Unmarried Separated Divorced Widowed

Siblings (Name, Age): ____

Home situation: Both parents Mother Father Relatives Adoptive parents Foster parents Other

Custody: Joint Mother Father Grandmother Grandfather Aunt Uncle Other

Changes in family/social situation: Yes No

Childcare: None Relative Private sitter Daycare/preschool

Year in school: Pre-K K 1 2 3 4 5 6 7 8 9 10 11 12 HS Grad College

School accommodations for medical problems: Yes No

School has plan for allergy/asthma: Yes No

Bully/Bullying: Yes No

On average, how many days per week do you engage in moderate to strenuous exercise? _________

Sporting activities: ____

How often do you drink a drink containing alcohol? Never Monthly or less 2-4 times/month 2-3 times/week 4+ times per week

How many standard drinks containing alcohol do you have on a typical day? 1-2 3-4 5-6 7-9 10+

How often do you have 6 or more alcoholic drinks on one occasion? Never Less than monthly Monthly Weekly Daily/Almost daily

Illicit dugs: No Yes: _________________________________ Prescription medication abuse: No Yes: ________________________

Passive smoke exposure? Yes No

Family History
Check all diseases that apply.

☐ Allergic conjunctivitis Family member(s): ____
☐ Allergic reaction to insect venom Family member(s): ____
☐ Allergic rhinitis (hay fever) Family member(s): ____
☐ Angioedema (swelling) Family member(s): ____
☐ Asthma Family member(s): ____
☐ Autoimmune disease Family member(s): ____
☐ Chronic obstructive lung disease Family member(s): ____
☐ Chronic sinusitis Family member(s): ____
☐ Cystic fibrosis Family member(s): ____
☐ Disorder of gastrointestinal tract Family member(s): ____
☐ Disorder if immune system Family member(s): ____
☐ Disorder of lung Family member(s): ____
☐ Disorder of thyroid gland Family member(s): ____
☐ Eczema Family member(s): ____
☐ Malignant neoplastic disease (cancer) Family member(s): ____
☐ Recurrent bacterial infections Family member(s): ____
☐ Urticaria (hives) Family member(s): ____

Environmental History:
Circle your answer(s) or fill in blanks.

Living situation: Single Family Home Townhouse Apartment (___ floor) Condo (___ floor) Dorm Trailer
Length of current living situation: Year you moved there- __________
Levels of living place: 1 2 3 4 5
Mold in house? Yes No
House foundation: Slab Crawl space Basement
Basement Finish: Finished Unfinished Partially Finished
Basement conditions/air quality: Ventilated Dry Musty Damp Seepage History of flooding Sump pump Dehumidifier
Basement flooring: Cement Carpet Tile Hardwood Ceramic Linoleum Other: ________________
Heating system: Gas Oil Electric Pellet Stove Propane Wood burning fireplace Gas fireplace Electric fireplace Wood stove
Humidifier: None Stand alone Central
Heat delivery: Forced air Radiator
Air conditions type: None Central unit Window units Ceiling fans Window fans
Air filter type: Standard High efficiency allergy filter Electrostatic Electronic HEPA Other: _______________
Bedroom floor level: 1 2 3 4 5
Bedroom flooring: Carpet Wood Tile Linoleum
Bed type: Air mattress Spring mattress Pillow top Foam Feather bed Futon Bunk bed Crib Water bed
Bed (mattress and boxspring) in allergy encasements? Yes No
Pillows in allergy encasements? Yes No
Bedroom ceiling fan? Yes No
Bedroom clutter? Yes No
Bedroom stuffed toys? Yes No
Pets in home? None Cat Dog Bird Reptile Small animal Horse Farm animals Exotic animal Other: ___________
Specify the number of each pet type: ____
Pet sleeping arrangement: In bed In bedroom Outside bedroom Outdoors
Specify which pet(s) are in bed or bedroom: ____
Animal exposure outside of home? No Yes, please explain: ______________________________________
Occupational exposure history/health risks: ____
Significant travel history: No Yes, please explain: ____