

Geist Center for Allergy, Asthma and Immunology, PC
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New Child Patient Questionnaire (Birth – 18 years)

Name: _____ Date of Birth: _____

Reason for visit: _____

Duration of Symptoms: _____ Severity: _____

Associated Signs/Symptoms: _____

Parts of the Body Affected: _____

What makes it better: _____

What makes it worse: _____

Medications tried (please indicate which helped and which did not): _____

Review of Systems

(Please check appropriate box of all that apply)

<u>General</u>	<u>Now</u>	<u>Past</u>	<u>Ears</u>	<u>Now</u>	<u>Past</u>
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	Hearing Loss	<input type="checkbox"/>	<input type="checkbox"/>
Fever	<input type="checkbox"/>	<input type="checkbox"/>	Earache	<input type="checkbox"/>	<input type="checkbox"/>
Weakness	<input type="checkbox"/>	<input type="checkbox"/>	Discharge	<input type="checkbox"/>	<input type="checkbox"/>
Weight Loss	<input type="checkbox"/>	<input type="checkbox"/>	ringing	<input type="checkbox"/>	<input type="checkbox"/>
			Itching	<input type="checkbox"/>	<input type="checkbox"/>
			Fullness	<input type="checkbox"/>	<input type="checkbox"/>
<u>Eyes</u>	<u>Now</u>	<u>Past</u>	<u>Nose</u>	<u>Now</u>	<u>Past</u>
Blurry	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding	<input type="checkbox"/>	<input type="checkbox"/>
Double Vision	<input type="checkbox"/>	<input type="checkbox"/>	Loss of Smell	<input type="checkbox"/>	<input type="checkbox"/>
Pain	<input type="checkbox"/>	<input type="checkbox"/>	Obstruction	<input type="checkbox"/>	<input type="checkbox"/>
Floaters	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Problem	<input type="checkbox"/>	<input type="checkbox"/>
Itching	<input type="checkbox"/>	<input type="checkbox"/>	Itching	<input type="checkbox"/>	<input type="checkbox"/>
Excess Tearing	<input type="checkbox"/>	<input type="checkbox"/>	Sneezing	<input type="checkbox"/>	<input type="checkbox"/>
Dryness	<input type="checkbox"/>	<input type="checkbox"/>	Runny	<input type="checkbox"/>	<input type="checkbox"/>
Redness	<input type="checkbox"/>	<input type="checkbox"/>	Nosebleeds	<input type="checkbox"/>	<input type="checkbox"/>
Yellow eyes	<input type="checkbox"/>	<input type="checkbox"/>			
<u>Mouth</u>	<u>Now</u>	<u>Past</u>	<u>Blood/Lymph</u>	<u>Now</u>	<u>Past</u>
Bad Breath	<input type="checkbox"/>	<input type="checkbox"/>	Bruising	<input type="checkbox"/>	<input type="checkbox"/>
Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding Gums	<input type="checkbox"/>	<input type="checkbox"/>
Dental Problem	<input type="checkbox"/>	<input type="checkbox"/>	Bone Pain	<input type="checkbox"/>	<input type="checkbox"/>

<u>Throat</u>	<u>Now</u>	<u>Past</u>	<u>Skin</u>	<u>Now</u>	<u>Past</u>
Soreness	<input type="checkbox"/>	<input type="checkbox"/>	Hives	<input type="checkbox"/>	<input type="checkbox"/>
Pain Swallowing	<input type="checkbox"/>	<input type="checkbox"/>	Rashes	<input type="checkbox"/>	<input type="checkbox"/>
Infections	<input type="checkbox"/>	<input type="checkbox"/>	Dryness	<input type="checkbox"/>	<input type="checkbox"/>
Itching/Tickle	<input type="checkbox"/>	<input type="checkbox"/>	Mole Changes	<input type="checkbox"/>	<input type="checkbox"/>
Swollen Glands	<input type="checkbox"/>	<input type="checkbox"/>	Sores	<input type="checkbox"/>	<input type="checkbox"/>
Tender Glands	<input type="checkbox"/>	<input type="checkbox"/>	Yellow Skin	<input type="checkbox"/>	<input type="checkbox"/>

<u>Head</u>	<u>Now</u>	<u>Past</u>	<u>Breast</u>	<u>Now</u>	<u>Past</u>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Lumps	<input type="checkbox"/>	<input type="checkbox"/>
Injuries	<input type="checkbox"/>	<input type="checkbox"/>	Pain	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Discharge	<input type="checkbox"/>	<input type="checkbox"/>

<u>Chest</u>	<u>Now</u>	<u>Past</u>	<u>Genitourinary</u>	<u>Now</u>	<u>Past</u>
Itching	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Urination	<input type="checkbox"/>	<input type="checkbox"/>
Short Breath	<input type="checkbox"/>	<input type="checkbox"/>	Pain Urinating	<input type="checkbox"/>	<input type="checkbox"/>
Cough	<input type="checkbox"/>	<input type="checkbox"/>	Leaking Urine	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Stones	<input type="checkbox"/>	<input type="checkbox"/>
Wheezing	<input type="checkbox"/>	<input type="checkbox"/>			

<u>Gastrointestinal</u>	<u>Now</u>	<u>Past</u>	<u>Heart</u>	<u>Now</u>	<u>Past</u>
Abdominal Pain	<input type="checkbox"/>	<input type="checkbox"/>	Cold Extremity	<input type="checkbox"/>	<input type="checkbox"/>
Nausea	<input type="checkbox"/>	<input type="checkbox"/>	Ankle Edema	<input type="checkbox"/>	<input type="checkbox"/>
Vomiting	<input type="checkbox"/>	<input type="checkbox"/>	Murmur	<input type="checkbox"/>	<input type="checkbox"/>
Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	Varicose Veins	<input type="checkbox"/>	<input type="checkbox"/>
Constipation	<input type="checkbox"/>	<input type="checkbox"/>	Blood Clots	<input type="checkbox"/>	<input type="checkbox"/>
Bloody Stool	<input type="checkbox"/>	<input type="checkbox"/>	Palpitations	<input type="checkbox"/>	<input type="checkbox"/>
Black Stool	<input type="checkbox"/>	<input type="checkbox"/>	Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>
Heartburn	<input type="checkbox"/>	<input type="checkbox"/>			
Hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>			
Burping	<input type="checkbox"/>	<input type="checkbox"/>			
Loss of Appetite	<input type="checkbox"/>	<input type="checkbox"/>			
Changes in Stool	<input type="checkbox"/>	<input type="checkbox"/>			

Medical History

Birth History Full Term Premature
 Vaginal delivery C-Section

Birth Weight: _____ List Complications if any: _____

- Asthma Recurrent Bronchitis Recurrent Pneumonia Recurrent Sinusitis
- Diabetes Glaucoma Hypertension
- Anxiety Bipolar Disorder Mental Health
- Headaches requiring preventive medication
- Any Joint Diseases (Please Specify): _____
- Any Other Autoimmune Disease (Lupus, +ANA, etc.)
- Other: _____

Date of last flu shot: _____ Date of last pneumonia shot: _____

List dates of any hospitalizations and reasons: _____

List dates of any ER visits and reasons: _____

List dates of any surgeries and the type of surgery: _____

Previous allergy testing? Yes No

If yes, please provide the following information:

Dates of testing: _____

Positive to: _____

Previous allergy injections? Yes No

Social History

Lives with: _____

	Yes	No
Pets	<input type="checkbox"/>	<input type="checkbox"/>

If yes, please provide number and type and if they sleep in the bedroom:

Type of home:

Apartment Single Family Dwelling Condominium

Home location:

City Suburb Countryside
 Close to body of water Close to wooded area

Year Built: _____

Home details:

	Yes	No
Mostly carpeted	<input type="checkbox"/>	<input type="checkbox"/>
Bedroom carpeted	<input type="checkbox"/>	<input type="checkbox"/>
History of floods or leaks	<input type="checkbox"/>	<input type="checkbox"/>

Method of heating:

	Yes	No
Forced air	<input type="checkbox"/>	<input type="checkbox"/>
Central air	<input type="checkbox"/>	<input type="checkbox"/>

Smoke Exposure Yes No

If yes, type and duration: _____

