Allergy & Asthma
Consultants of Mid-Michigan

**Ridhu C. Burton, M.D.**
**Ravinder R. Polasani, M.D.**
James H. Saker, M.D.
Clyde R. Flory, M.D.
*Diplomates of the American Board of Allergy & Clinical Immunology*

# ***Pediatric Medical History***

How did you hear about our office?

___Referral by another physician ___Referral by another patient
___Phonebook listing ____ Internet Ad; Please circle one Google, Bing or Yahoo
___Other: _____

Name:_____ DOB:_____

**I. Reason for evaluation:**

A. Reason your child was sent to an allergist:_____
_____

**II. If patient has ASTHMA symptoms fill out the following:**

A. What are your child's symptoms?
____ Cough _____Wheeze _____Shortness of Breath

B. What age did symptoms begin?_____

C. How frequent are the symptoms?
___< 2 x per week ___> 2 x per week ___Daily

D. Any hospitalizations, urgent care or emergency room visits for asthma? ____Yes _____No
List when and where _____
_____

**III. Nasal symptoms**

____Itching ____Sneezing
____Nasal discharge
____Nasal congestion ____Snoring ____Mouth Breathing
____Clearing of throat ____Postnasal drainage

A. When are symptoms worse?
____ All year ____Spring ____Summer ____Fall ____Winter

**IV. Other Symptoms**

Eyes: ____Itching _____Redness/tearing/discharge ____Seasonal ____Year round

Ears: ____Earaches _____Infections _____Hearing loss _____Ear tubes When?_____

Infections: How many of the following per year?
_____Colds/year ____Bronchitis/Pneumonia ____ Sinusitis
_____Ear Infections ____Tonsillitis

Skin: ____Eczem ____Hives

Allergy & Asthma
Consultants of Mid-Michigan

**Ridhu C. Burton, M.D.**
**Ravinder R. Polasani, M.D.**
James H. Saker, M.D.
Clyde R. Flory, M.D.
*Diplomates of the American Board of Allergy & Clinical Immunology*

V. **Do foods cause any symptoms?**
Name Food and Associated Symptoms
Food:_____ Symptoms:_____
Food:_____ Symptoms:_____
Food:_____ Symptoms:_____
(hives, rash, runny nose, nauseas or vomiting, diarrhea, headache)

VI. **Quality of life:**
A. Do symptoms affect the following:
_____School _____Work _____Missed days _____Sleep _____ Sports

VII. **Growth and Development**
A. Birth weight: _____
B. Breast fed: ___No ____Yes If yes, how long _____
C. Immunizations: _____Complete _____Incomplete _____ Reactions
D. Surgeries or Hospitalizations (dates if known):
1. _____ 3. _____
2. _____ 4. _____

VIII. **Family History**

| | Father | Mother | Brothers | Sisters |
|---|---|---|---|---|
| Age | | | | |
| Hay Fever/ Sinus Trouble | | | | |
| Asthma | | | | |
| Eczema | | | | |
| Hives | | | | |

A. Does any illness run on either side of the family?_____

I. **Living Environment-Circle the following**
A. **Type of structure: Home Apartment Mobile Home**
**Location of Home: Urban Rural Suburban**
Proximal to: Factories Granaries Farm
Approximate age of home:_____ How long have you lived there?_____
**Any smokers in residence? Yes No Exposed to Second hand smoke? Yes No**

B. **Do you have the following: Basement Crawl Space Slab**
Type of basement: Block Poured Finished Michigan cellar
**Basement in winter: Dry Damp Basement in summer: Dry Damp**
Basement musty or moldy: Yes No Basement leaks with rain: Yes No
**Dehumidifier in basement: Yes No** Symptoms worse in basement: Yes No

C. Type of Furnace: Gas Wood Oil Electric Coal
Location of furnace: Basement Crawl space 1st floor
**Heating system: Forced air Radiator Steam Fireplace Space heater**
Type of Filters: Disposable Permanent Electrostatic **How often is filter changed:_____**
**Central air conditioning: Yes No** Room air cleaner: Yes No

Allergy & Asthma
Consultants of Mid-Michigan

**Ridhu C. Burton, M.D.**
**Ravinder R. Polasani, M.D.**
James H. Saker, M.D.
Clyde R. Flory, M.D.
*Diplomates of the American Board of Allergy & Clinical Immunology*

**Humidifier on furnace: Yes No** Portable humidifier location_____
Fireplace or wood burning stove: Yes No

D. Patient's Bedroom location: Basement 1st floor Upper floor
**Bedroom Floor coverings: Carpet (shag) Carpet (short pile) Wood Tile Vinyl**
**Living Area Floor coverings: Carpet (shag) Carpet (short pile) Wood Tile Vinyl**
Bed coverings: Feather comforter _____Yes _____No
**Pillow(s): Polyester Foam Feather Cotton Pillow age____ Are pillows encased? Yes No**
Mattress: Cotton innerspring Foam Water Feather Mattress age_____
**Is Mattress encased? Yes No Is Box Spring encased? Yes No**
**Pets in bedroom: Yes No**

E. Is there mold growing anywhere in the house:_____

F. Is there anything in your building, yard, or around your house that has not been mentioned that you think is significant in contributing to your child's problems?_____
_____
_____

G. Is the child exposed to second hand smoke: Yes No

IX. **Inhalant History**

A. Dust: Dust exposure may cause either Nasal or Lung symptoms or both. With the following dust exposures, indicate which symptoms are worse by circling "N" to indicate Nasal, "L" to indicate Lung, "O" to indicate None, and "U" to indicate Unknown.

Dusty garage: N L O U Breathing house dust: N L O U
Outdoor dust: N L O U Dusting and/or vacuuming: N L O U
Feathers N L O U

B. Molds: Does your child's symptoms worsen after exposure to the following:

Hay: Yes No Unknown Raking Leaves: Yes No Unknown
Barns: Yes No Unknown Cut dried grass/fresh cut grass: Yes No Unknown
Damp Basements: Yes No Unknown Eating mushrooms: Yes No Unknown
Eating cheese: Yes No Unknown

C. Danders: Please indicate the number of pets you own, their age and circle whether they are indoor or outdoor.

Cat #_____ Age_____ Outdoor/Indoor/Bedroom
Dog #_____ Age_____ Outdoor/Indoor/Bedroom
Parakeet #_____ Age_____ Outdoor/Indoor/Bedroom
Other #_____ Age_____ Outdoor/Indoor/Bedroom

What animals aggravate your child's symptoms?_____
_____
Any animals at child care? Yes No If yes, what animals:_____

Allergy & Asthma
Consultants of Mid-Michigan

**Ridhu C. Burton, M.D.**
**Ravinder R. Polasani, M.D.**
James H. Saker, M.D.
Clyde R. Flory, M.D.
*Diplomates of the American Board of Allergy & Clinical Immunology*

X. **Drugs**

A. Has your child ever had an adverse or allergic reaction to any medication?

| Drug | Reaction | Date |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

XI. **Insect Stings**:

A. Has your child ever had an unusual reaction from an insect sting? Yes No
Date:_____ Type of insect: _____
Type of reaction:_____
_____

XII. **Medications (this is very important)**

A. List all current medications including **strength and how many times your child takes it**:

Med Name: Strength (i.e. mg): Frequency:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

XIII. **Prescription Pharmacy**

1. Local Pharmacy: _____
   Address: _____
   Phone #: _____
2. Mail Order Pharmacy: _____

**XV. Has your child had the Influenza Vaccine? What was the date of the last Influenza Vaccine?**

No___ Yes____ Date:_____