Boston Children's Hospital

LABEL OR PRINT
NAME

CH MRN

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ALLERGY NEW PATIENT HISTORY
Allergy Program

Date of Birth

Patient's Last Name	Patient's First Name	Patient Phone #

Primary Care Physician/Pediatrician:	Who referred you to the Allergy Program? ☐ My child's primary care provider ☐ A friend/relative ☐ Self-referred ☐ Another physician:
PCP Address:	Other doctors involved with your child's care:

Do you want a letter sent to: ☐ My child's primary care provider ☐ Referring MD ☐ Another physician:

Please tell us about the problem or question that brought your child to the Children's Hospital Allergy Program:

Describe any special testing or procedures related to this problem (e.g. allergy testing, blood tests, X-rays/scans, endoscopies)?

What medicines is your child currently taking?

Medicine	Last time given?	Dose	Taken how often?	How well does it work?		
				Very Well	Just OK	Not at all

Is your child taking any alternative or homeopathic medicines? If yes, please list.

What other medicines have you previously tried for your child's problem?

Medicine	How long ago was the medicine stopped?	Length of time on the medicine	Reason for stopping the medicine

Is your child allergic to medications or latex? Please describe:

Is your child allergic to any foods? Are any foods currently being restricted from your child's diet? Please describe:

BOSTON CHILDREN'S HOSPITAL, 300 LONGWOOD AVE., BOSTON, MA 02115

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Has your child been diagnosed or suspected to have any of the following:

Asthma? ☐ **Yes** ☐ **No**
If yes: Has your child been hospitalized? ☐ Yes ☐ No In the ICU? ☐ Yes ☐ No Intubated? ☐ Yes ☐ No
Has symptoms with exercise/activity? ☐ Yes ☐ No Taken oral steroids? ☐ Yes ☐ No If yes, how often? _____

Eczema? ☐ **Yes** ☐ **No**
If yes: What skin moisturizers are used? _____ How often does your child bathe? _____
Difficulty sleeping due to itching? ☐ Yes ☐ No Has your child had skin infections? ☐ Yes ☐ No
Has your child had eczema herpeticum? ☐ Yes ☐ No
Has your child had a drug resistant staph aureus infection (MRSA)? ☐ Yes ☐ No (If yes, please notify clinic upon arrival)

Nasal/Eye Allergies? ☐ **Yes** ☐ **No**
If yes: What symptoms? ☐ Sneezing ☐ Congestion ☐ Post-nasal drip ☐ Runny nose ☐ Red itchy eyes
☐ Other symptoms _____ What triggers your child's symptoms? _____
What seasons are worse? ☐ Spring ☐ Summer ☐ Fall ☐ Winter ☐ Always bad

Increased frequency/severity of infections? ☐ **Yes** ☐ **No**
If yes: What type of infections? ☐ Ear infections ☐ Sinus infections ☐ Pneumonias ☐ Bronchitis ☐ Other _____
How many course of antibiotics has your child taken in the past 12 months? _____

Was your child born ☐ Full-term ☐ Premature ☐ Via normal delivery ☐ Via C-section ☐ Requiring supplemental oxygen

Has your child had any other medical problems or diagnoses? _____

_____

_____

_____

Has your child been hospitalized or had any surgeries (If yes, please describe)? _____

_____

Are your child's immunizations up to date? ☐ **Yes** ☐ **No**
Did your child receive the influenza vaccine this year? ☐ **Yes** ☐ **No**

SOCIAL HISTORY:

Father's/Guardian's Occupation: _____ **Siblings and their ages** _____
Mother's/Guardian's Occupation: _____ _____
_____

Who are the legal guardians? ☐ **Mother** ☐ **Father** ☐ **Both** ☐ **Other** _____
Does your child attend school/daycare? ☐ **Yes** ☐ **No**
If yes: What grade? _____ **Number of days of missed school this year?** _____
Your child participates in what types of sports/activities? _____

FAMILY HISTORY: Please indicate if the patient's parents, grandparents, or siblings have had any of the following conditions:

Condition	Relation to patient	Condition	Relation to patient
Cystic Fibrosis		Celiac Disease	
Thyroid Disease		Other Autoimmune Disease	

☐ **No family history of any of the above**

	Asthma	Nasal/Eye Allergy	Eczema	Food Allergy	Drug Allergy	Frequent Infections
Mother						
Father						
Brothers and sisters						
Mother's brothers and sisters						
Father's brothers and sisters						
Mother's parents						
Father's parents						

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ENVIRONMENTAL HISTORY:

Does your child live in: ☐ An apartment ☐ A house ☐ A multifamily house/condo ☐ Other _____

☐ Multiple home settings _____

Do you have a basement? ☐ Yes ☐ No **If Yes:** Is it ☐ Finished ☐ Dry ☐ Damp ☐ Has flooded

Climate Control: ☐ Hot water heat ☐ Steam heat ☐ Forced hot air ☐ Wood stove ☐ Space heater
☐ Central A/C ☐ Window A/C ☐ Air filters ☐ Air cleaner/purifier
☐ Humidifier ☐ Dehumidifier ☐ Other _____

Does your home have? ☐ Mold or mildew ☐ Damp or musty smell ☐ Water stains ☐ Mice ☐ Cockroaches ☐ None

Flooring: ☐ Hardwood ☐ Tile/linoleum ☐ Wall to wall carpeting ☐ Area rugs ☐ Other _____

Exposure to Pets: ☐ No ☐ Yes (If yes, please describe): _____

Do you or any of your child's caretakers smoke? ☐ No ☐ Yes (who)? _____

Does your child's bedroom have? ☐ Stuffed animals ☐ Rugs ☐ Carpeting ☐ Blinds ☐ Curtains
☐ Air conditioning ☐ Humidifier ☐ Feather pillow ☐ Down comforter
☐ Air cleaner/purifier ☐ Allergy-proof mattress or pillow covers

School, work or day care environment (please describe) _____

REVIEW OF SYSTEMS

Has your child been experiencing or diagnosed with any of the following?
Mark N/A if unable to assess

Constitutional	Yes	No	N/A
Feeling tired			
Fevers			
Chills or night sweats			
Poor weight gain			
Changes in appetite			

Ophthalmologic	Yes	No	N/A
Red or itchy eyes			
Blurred or altered vision			
Sensitivity to light			

Ear/Nose/Throat	Yes	No	N/A
Nasal congestion/snoring			
Post nasal drip/nasal discharge			
Ear or throat pain			
Nose bleeds			
Nasal polyps			
Loss of smell			

Urinary	Yes	No	N/A
Pain with urination			
Increased frequency of urination			
Urine infections			

Respiratory	Yes	No	N/A
Cough			
Shortness of breath			
Wheezing			

Cardiac	Yes	No	N/A
Heart murmur			
Heart palpitations/irregular heartbeat			
Heart defects			

Gastrointestinal	Yes	No	N/A
Diarrhea			
Constipation			
Abdominal pain			
Nausea/Vomiting			
Acid reflux/heartburn			
Blood in stool			
Enlarged liver or spleen			

Hematologic	Yes	No	N/A
Easy bruising or bleeding			
Swollen glands			
Anemia			
Low white blood cell/platelet counts			

Endocrine	Yes	No	N/A
Excessive thirst			
Hot or cold intolerance			
Thyroid disorders			
Diabetes			
Delayed puberty			

Skin	Yes	No	N/A
Rash			
Birth marks or large moles			

Musculoskeletal	Yes	No	N/A
Muscle pain			
Joint pain/swelling			

Neurologic	Yes	No	N/A
Headaches			
Dizziness or lightheadedness			
Weakness/numbness/tingling			
Seizures			

Psychiatric	Yes	No	N/A
Hyperactivity disorder			
Depression or anxiety			
Sleep disturbances			

Further Details or other symptoms: _____

_____

_____

_____

Person completeing this form | **Relationship to patient** | **Date**

Clinician Signature / Title | **Print** | **TIME** | **Date**