UCDAVIS HEALTH | CHILDREN'S HOSPITAL

Allergy, Immunology and Rheumatology

Allergy Patient Questionnaire

Date: ________________

What is your main concern today?

____

ALLERGIES

Any Allergy Symptoms? Please Circle:

Symptom	
Itchy or Red Eyes	**Yes / No**
Eye swelling	**Yes / No**
Stuffy nose	**Yes / No**
Runny nose	**Yes / No**
Itchy nose	**Yes / No**
Sneezing	**Yes / No**
Snoring	**Yes / No**
Post-nasal drip	**Yes / No**
Bloody nose	**Yes / No**

When do these symptoms bother your child?

❑ Spring ❑ Summer ❑ Fall ❑ Winter

What medications do you use?

______________ ________________

______________ ________________

Have you seen an allergist in the past? Yes / No

Have you been tested for allergies? Yes / No

Does your child have any reactions to the following?

Food ____________	**Yes / No**
Insect Stings	**Yes / No**
Latex/ Rubber	**Yes / No**
Antibiotics	**Yes / No**
Medicine	**Yes / No**
Aspirin	**Yes / No**
Ibuprofen	**Yes / No**

BREATHING

Was your child hospitalized for asthma in the past year? Yes / No

Has your child gone to the ER for asthma in the past year? Yes / No

Last time oral steroids were used for asthma (if applicable): __________

Any Chest Symptoms in the past 6 months?

❑ Asthma
❑ Shortness of Breath
❑ Cough
❑ Chest Tightness
❑ Trouble Breathing or Cough with Exercise
❑ Wheezing
❑ Nighttime Symptoms

SKIN

Any Skin Symptoms?

Eczema/Atopic Dermatitis	**Yes / No**
Hives	**Yes / No**
Itchy Skin	**Yes / No**
Other Skin Condition: ________________	**Yes / No**

ENVIRONMENT

Any smokers inside or outside your home? Yes / No

In your home, do you have:

Wall-to-wall carpet	**Yes / No**
Central AC	**Yes / No**
Window AC	**Yes / No**
Swamp Cooler	**Yes / No**
Fireplace or wood burning stove	**Yes / No**
History of mold	**Yes / No**
Pets (what kind):	**Cat Dog Birds Other**

MEDICAL HISTORY

Does your child have a history of the following?

Ear Infections	**Yes / No**
Sinus Infections	**Yes / No**
Pneumonia	**Yes / No**
Skin Infections	**Yes / No**
Autoimmune Diseases (e.g.,: Arthritis, Lupus, Thyroid Disease, Low Blood Counts) ________________	**Yes / No**
Surgeries (please describe): ________________	**Yes / No**
Other recurrent, severe, or unusual infections: ________________	**Yes / No**

FAMILY HISTORY

Does anyone in your family have the following:

Asthma	**Mom / Dad / Other**
Seasonal Allergies	**Mom / Dad / Other**
Eczema	**Mom / Dad / Other**
Food Allergy	**Mom / Dad / Other**
Autoimmune Diseases (describe) ________________	**Mom / Dad / Other**
Recurrent, severe, or unusual infections (describe) ________________	**Mom / Dad / Other**

REVIEW OF SYSTEMS

******Over the past 3 months has your child had any of the following symptoms? If not, circle "NONE."*****

General	Fatigue	Fevers	Night Sweats	Weight Gain	Weight Loss	**NONE**
Eyes	Vision Changes	Frequent Drainage	Infections			**NONE**
Ears	Hearing Loss	Infections				**NONE**
Mouth	Lip Swelling	Tongue Swelling	Dental Problems	Thrush	Oral Ulcers	**NONE**
Cardio	Chest Pain	Palpitations				**NONE**
Gastro	Abdominal Pain	Reflux	Nausea	Vomiting	Diarrhea	**NONE**
MSK	Muscle Aches	Joint Pain	Joint Swelling			**NONE**
Neuro	Headaches	Seizures	Dizziness	Numbness or Tingling		**NONE**
Psych	Anxiety	Depression	Difficulty Sleeping			**NONE**
Heme	Easy Bruising	Easy Bleeding	"Low" Blood Levels			**NONE**
Allergy/Immunology, Respiratory, Nasal, and Skin as reviewed above						

Parent Signature: ________________________ **Reviewed by:** ________________ **Date:** __________