

# Pediatric Asthma/Allergy Questionnaire

Name \_\_\_\_\_ Person filling out form: \_\_\_\_\_ Date: \_\_\_\_\_  
Personal Physician: \_\_\_\_\_

What is the main problem: \_\_\_\_\_  
How Long? \_\_\_\_\_ When? Spring Summer Fall Winter Inside Outside School Pets Colds  
What treatments have been given: \_\_\_\_\_

(Circle any positive or problem areas)

## Systemic Review

General-Growth, Development, Fatigue, Irritability, Skin-dry, rash itch, Eyes-red, itch, discharge, Ears, Nose, Throat-congestion, drainage, Heart-disease, hypertension, Chest-wheeze, cough, pain short of breath, GI-nausea, pain diarrhea, constipation, GU-problems urinating, periods, MS-muscle or joint pain, Neuro-seizures, fainting, headaches, Endocrine-diabetes, heat, cold intolerance, hair/skin changes, Bleeding problems, anemia, Allergy/Immunology-numerous, unusual, persistent infections, hives, shock, Psych-depression, anxiety, stress Other symptoms: \_\_\_\_\_

## Past History

Pregnancy, Birth, Nursery, Infancy complications: \_\_\_\_\_  
Breast fed to \_\_\_\_\_ mo Formula \_\_\_\_\_ to \_\_\_\_\_ mo Changed to \_\_\_\_\_  
Colic, Spitting, Diarrhea, Constipation: \_\_\_\_\_  
Immunization, Food, Drug reactions: \_\_\_\_\_  
Hospitalizations, Surgery Dates: \_\_\_\_\_  
Pneumonia, Bronchitis, Ear, Sinus, Skin Infections, Wheezing: \_\_\_\_\_  
School Missed Last Year 0-5, 6-10, 11-20, >20, Number of antibiotics: \_\_\_\_\_ Steroids: \_\_\_\_\_

## Family History

M-Mother F-Father PGF-Father's father MGM-Mother's Mother B-Brother A-Aunt etc  
Asthma \_\_\_\_\_ Bronchitis \_\_\_\_\_ Eczema \_\_\_\_\_ Hayfever \_\_\_\_\_  
Hives \_\_\_\_\_ Drug Allergies \_\_\_\_\_ Other allergies \_\_\_\_\_ Sinus \_\_\_\_\_  
Gastrointestinal \_\_\_\_\_ Migraine \_\_\_\_\_ TB \_\_\_\_\_ Chronic disease \_\_\_\_\_

## Environmental Review

House \_\_\_\_\_ years old, Apartment, Farm, Damp Basement. Humidifier, Filter  
Heat-Electric, Hot Air, Water, Coal, Wood, Propane, Kerosene, Air Conditioner -  
Pets inside-Cat(s) \_\_\_\_\_ Dog(s) \_\_\_\_\_ Bird(s) \_\_\_\_\_ Other \_\_\_\_\_ Pests(mice, roachs) \_\_\_\_\_  
Bedroom-Wall to Wall or Area Carpet, Stuffed animals, furniture, books, other \_\_\_\_\_  
Smoking in house/car M F Other, Scented Candles, Hair sprays, Air Fresheners Etc.  
Face/hand soap; \_\_\_\_\_ Laundry soap \_\_\_\_\_ Fabric Softener/dryer sheet \_\_\_\_\_

What else would you like the allergist to know: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_