Please answer **all** questions on the following **three** pages to the best of your ability.

1.) Briefly describe the problem(s) which have caused you to see the doctor today. ______________________________
____

2.) Has your child ever been hospitalized or seen in the emergency room for this/these problem(s)? Yes____ No__
(If yes, state when.) ____

3.) Which time of day are your child's symptoms worse? (circle) Morning Afternoon Evening Nighttime

4.) Do the symptoms ever awaken your child at night? Yes___ No_____ If yes, how often?______________

5.) Are the symptoms worse during certain seasons? Yes____ No____

If yes, which season? (circle) Winter Spring Summer Fall

7.) Are your child's symptoms triggered or worsened by exposure to any of the following **allergens**? (circle)
Dust Pollens Cats Dogs Mold (raking leaves, hay rides, damp basements) Other ___________

8.) Are your child's symptoms triggered or worsened by exposure to any of the following **irritants**? (circle)

Smoke Perfumes Strong Odors Cold Air Exercise Other ____________________

9.) Please list other factors which you feel are associated with triggering your child's symptoms. ______________

10.) Please list the names of **<u>all</u>** medications your child is currently taking, including over the counter_________________
____

11.) Please list any drug allergies: ____

Other physicians your child has seen for this/ these problems: _____________________ _________________

<u>PAST HISTORY</u>

Birth History

Born where? _______________________________ Birth Weight :________________________

Length of Pregnancy ______________ Any complications with delivery?______________________

Feeding History

Breast (how long?)____ Formula _____ Any troubles with feeding (vomiting, gas, diarrhea, etc.)? __________

Immunizations

(Up to Date?)______________________

Any adverse reactions ? _________________________

Illnesses

Has your child ever been **diagnosed** with any of the following? (Please check **YES** or **NO**)

	<u>YES</u>	**<u>NO</u>**	<u>Physician Comments</u>
Asthma	_____	____	
Hay fever/ Allergic Rhinitis	_____	____	
Sinus Problems	_____	____	
Ear infections/ fluid in ears	_____	____	
Eczema/ Dermatitis	_____	____	
Bronchitis	_____	____	
Bronchiolitis	_____	____	
Pneumonia	_____	____	
Chicken Pox	_____	____	
Measles	_____	____	
Croup	_____	____	
Arthritis/ Joint aches	_____	____	

Other: ____

Any Surgeries? ____

Any Blood Transfusions? Yes No

Any Hospitalizations? ______________________________________

Reviewed By ________ M.D.

ENVIRONMENTAL SURVEY
Please **check** or **complete** the answers to describe your home.

Type of Home: House____ Apartment____ Other_____________

Approximate age of home: _____ years Years of occupancy_____

Location: City____ Suburban____ Country____

Near your home is there a: Barn___ Prairie___ Factory____ Other________

Obvious mold/mildew? Yes / No Lots of dust? Yes / No Roaches? Yes / No

Heating System: Forced Air___ Radiator___ Baseboard___ Other_______________

Air Conditioning: Central___ Window units___ Fans___ How often do you change the air filter?________
In the spring / summer / fall windows are primarily kept: Open ____
Closed ____

Floor coverings: Carpet___ Area rug___ Wood___ Other_____

Is there a basement or crawl space? Yes___ No ___
If yes, do you spend much time in the basement? ___Yes ___No
Is the basement damp or musty? Yes___ No ___

BEDROOM
Located in : Basement___ First Floor___ Second Floor___ Attic___

Floor Covering Carpet___ Area rug ___ Wood___ Other__________

Bed mattress: Conventional___ Futon ___ Water___

Pillows: Synthetic/Foam____ Feather/Down_____

Comforter: Cotton/Synthetic _____ Feather/Down _____ Wool ____

Household Pets: Cat_____ Dog_____ Bird_____ Other__________
Do they go into the bedroom? Yes___ No___

SMOKERS IN FAMILY **No** **Yes** (who?)

Did Parent or Caretaker previously smoke around the child (at home, in car, in restaurants)? **No** **Yes** (Who)?

PARENT's OCCUPATION: Mother_______________________ Father______________________

SCHOOL HISTORY:
Does or did your child attend daycare or preschool ? _____________________

How many days of school (day care) per year has your child missed due to illness ?__________________________

Does your child have symptoms during gym class or other activity ? ______________________

Does your child take any medications at school (day care) ? ______________________________

Is your child exposed to any of the following at school (day care) ? **(circle)**

Animals (rabbits, mice, etc.) Dusts Chemicals Smoking Other_________________

Reviewed By ________ M.D.

Family History: Please **check** all that apply to members of your family.

	Mother	Father	Siblings	Other Relative	Physician Comment
Allergic Rhinitis(Hay Fever)					
Asthma					
Sinus Problems					
Nasal Polyps					
Hives/ Swelling					
Eczema/ Dermatitis					
Drug Allergy					
Food Allergy					
Stinging Insect Allergy					
Emphysema/ COPD					
Chronic Bronchitis					
High Blood Pressure					
Heart Disease					
Diabetes					
Thyroid disorder					
Cancer					
Other ________________					

Review of Systems:

Please **circle** any of the following symptoms which your child is **currently experiencing** or which caused **serious** problems in the past.

General:	fever, night sweats, weight changes, fatigue, loss of appetite
Eyes:	itching, tearing, dry eyes, redness, swelling, discharge
Ears:	ear fullness, popping, itching, loss of hearing, infections
Nose:	sneezing, itching, runny nose, stuffy/congested, yellow/green discharge
Throat:	sore throat, post nasal drip, itchy palate
Lymph glands:	glandular swelling, glandular tenderness
Chest:	cough, nighttime cough, wheezing, frequent respiratory infections, shortness of breath
Intestinal Tract:	nausea, vomiting, indigestion, trouble swallowing, stomach pain, constipation, diarrhea, excessive gas
Urinary:	trouble with urination, frequent urination, burning, urinary infections,
Rheumatologic:	joint stiffness, joint swelling, joint pain,
Skin:	rash, hives, welts, itching, eczema, hair loss
Neurologic:	black outs, severe headaches, epilepsy(seizures), inability to concentrate, trouble sleeping

Other:

All Others Neg.____

Reviewed By ________ M.D.