PATIENT NAME:_______________________________ DATE: _______________________ D.O.B______________

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 **all** 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: ______________________ __________________

PAST HISTORY

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**)

	YES	NO	Physician Comments
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.

PATIENT NAME:_______________________________ DATE: _______________________ D.O.B______________

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 ___ Is the basement damp or musty? Yes___ No ___
If yes, do you spend much time in the basement? ___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.

PATIENT NAME:______________________________ DATE: ______________________ D.O.B_____________

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.