Whitewater Immunology
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Pediatric History Questionnaire (age <17 yrs)

PLEASE PRINT. BRING THIS COMPLETELY FILLED OUT FORM TO YOUR APPOINTMENT.

BRING ALL YOUR CHILD'S MEDICATIONS/VITAMINS WITH YOU TO THE APPOINTMENT.

Child's Name:_____

Guardian or Mother's Name: _____ Home/cell # _____Work phone #_____

Guardian or Father's Name: _____ Home/cell # _____Work phone #_____

Parents e-mail addresses:_____

Preferred pharmacy and phone number: _____

Primary Care Physician:	*Referring Physician (if different):*
Name: _____	Name: _____
Telephone: _____	Telephone: _____

Reason for your child's visit to the allergy, asthma and immunology clinic:

_____

_____

_____

Approximate date symptoms began _____

Things that make symptoms worse_____

Are symptoms worse in (circle all): Spring Winter Summer Fall year-round change of seasons

Medications that have helped _____

Medications that have not helped _____

Has your child ever taken oral corticosteroids (e.g. Prednisone/Prednisolone)? Y N

Date of last treatment with corticosteroids _____

Has your child been to the emergency room for treatment? _____

Date of last emergency room visit _____

Does your son/daughter have an Epi injector? Y N Exp date:_____

Does he/she awake at night with shortness of breath or cough? _____

How is his/her sense of smell (if old enough to tell you)? Excellent____Good ___ Poor/Absent ____

Does he/she have any problems with voice/language? _____

Has your child had infections? ☐ Ear (# times_____) ☐ Skin ☐ Pneumonia ☐ RSV ☐ Chicken pox

How often has he/she been prescribed antibiotics? _____

Does anyone else in your family have problems with infections?_____

Length of Pregnancy: ☐ Term ☐ Early (# of weeks____) Birth weight ___lbs ___oz C-section? Y N

Any problems with pregnancy, labor or delivery? _____

Has she/he ever been intubated (other than for surgery)? _____

What is your child's growth pattern? ☐ Normal ☐ Slow Development? ☐ Normal ☐ Delayed

Are your child's immunizations up to date? ☐ Yes ☐ No

Has your child had a flu shot this year? ☐ Yes ☐ No COVID vaccine? ☐ Yes ☐ No

Do you have difficulty getting your child to take medications? ☐ Yes ☐ No

Food allergy/eczema specific questions (ok to skip to **Allergy History** if not here for evaluation of food allergy)

Was your child breast fed? ☐ No ☐ Yes (# months _____)

Was your child formula fed? ☐ No ☐ Yes (specify formula type _____☐ cow ☐ soy)

Does/did your child have colic? ☐ No ☐ Yes Acid Reflux? ☐ No ☐ Yes

Is your child allergic to foods? If yes, mark all that apply)

☐ Milk ☐ Soy ☐ Wheat ☐ Peanuts ☐ Tree nuts (walnuts, etc) ☐ Fish ☐ Shellfish

Other (specify): _____

Allergy History

Is your child allergic to: Animals ☐ No ☐ Yes (Specify _____)

Medications ☐ No ☐ Yes (Specify _____)

If amoxicillin give approx. date & reaction: _____

Bees, Wasps, Ants ☐ No ☐ Yes (type of reaction _____)

Eczema/atopic dermatitis? ☐ No ☐ Yes triggers: _____

Hives or swelling? ☐ No ☐ Yes triggers: _____

Nasal symptoms? ☐ No ☐ Yes When? ☐ Spring ☐ Summer ☐ Fall ☐ Winter or ☐ around animals_____

Itchy eyes? ☐ No ☐ Yes When? ☐ Spring ☐ Summer ☐ Fall ☐ Winter or ☐ around animals_____

Asthma triggers? ☐ No ☐ Yes When? ☐ Spring ☐ Summer ☐ Fall ☐ Winter or ☐ around animals____

Other triggers (exercise, smoke and/or infections): _____

Other medical problems:

_____

_____

Surgeries (ear tubes, tonsillectomy, appendectomy, wisdom teeth, etc):

_____

_____

Family Medical History:

Child's Guardian or Father (age ____) Occupation (for allergen exposures): _____

Child's Guardian or Mother (age ___) Occupation (for allergen exposures): _____

Other Caregivers (step mother/step father) Occupation(s): _____

Father: Allergies (environmental or food) Eczema Asthma Other:_____

Mother: Allergies (environmental or food) Eczema Asthma Other:_____

Sibling #1 Name: _____(☐ M ☐ F age ____) Allergies (environmental or food) Eczema Asthma
Sibling #2 Name: _____(☐ M ☐ F age ____) Allergies (environmental or food) Eczema Asthma
Sibling #3 Name: _____(☐ M ☐ F age ____) Allergies (environmental or food) Eczema Asthma
Sibling #4 Name: _____(☐ M ☐ F age ____) Allergies (environmental or food) Eczema Asthma

Maternal Grandfather Asthma Allergies COPD HTN High Chol DM Other: _____
Maternal Grandmother Asthma Allergies COPD HTN High Chol DM Other: _____
Paternal Grandmother Asthma Allergies COPD HTN High Chol DM Other: _____
Paternal Grandfather Asthma Allergies COPD HTN High Chol DM Other: _____

Other family medical problems - recurrent infections, eosinophilic esophagitis, cystic fibrosis (please detail):
_____
_____

Social History:

Parents' Marital Status: ☐ Married ☐ Divorced ☐ Separated ☐ Single ☐Other: _____
Child lives with: ☐ Both parents ☐ Father ☐ Mother ☐ Alternates ☐ Other: _____
Child's school grade: _____Attend daycare? ☐ No ☐ Yes (# other kids _____)
Type of exercise/sports: _____
Time spent per day: watching TV____hrs video games_____ hrs iPOD____hrs outside play ____hrs

Tobacco Smoke Exposure: ☐ None ☐ Third hand only ☐ Yes (who from/where? _____)
Vaping Exposure: ☐ None ☐ Third hand only ☐ Yes (who from/where? _____)

Living Environment:

☐ House or ☐ apartment ☐ mobile home Other:_____

Type of heat? ☐ forced air ☐ electric ☐ radiator ☐ wood stove

Carpet?	Yes ☐	No ☐	Swamp cooler?	Yes ☐	No ☐
Humidifier used consistently?	Yes ☐	No ☐	Water damage to home?	Yes ☐	No ☐
Hot tub?	Yes ☐	No ☐	Mold in basement or home?	Yes ☐	No ☐
HEPA filter?	Yes ☐	No ☐	Feather pillow or bedding	Yes ☐	No ☐

Pets:			Access to Bedroom?		Sleep in the Bed?	
Dogs (#)	Yes ☐	No ☐	Yes ☐	No ☐	Yes ☐	No ☐
Cats (#)	Yes ☐	No ☐	Yes ☐	No ☐	Yes ☐	No ☐
Birds (#)	Yes ☐	No ☐	Yes ☐	No ☐	Yes ☐	No ☐

Other animals:_____

Review of Systems (circle any that apply to your child):

General: weight gain weight loss fevers chills fatigue trouble sleeping
loss of appetite picky eater difficult to console frequent nightmares

Skin: rashes hives dry itchy eczema/atopic dermatitis skin infections problems w/ nails or hair

Head and eyes: headaches itchy eyes red eyes "shiners"

Nose, mouth and throat: sinus problems runny nose post nasal drip nasal congestion loss of smell mouth breathing frequent sore throat recurrent sinus infections trouble swallowing large lymph nodes excessive cavities problems with baby teeth thrush/yeast/candida infections

Lungs: dry cough wheezing asthma productive cough (color of sputum_____)
trouble breathing in trouble breathing out shortness of breath shortness of breath with exercise
oxygen needed: Y N pneumonia (# times_____) frequent viral infections (# per year_____)

Heart: heart murmur dizziness irregular heart beat other: _____

Digestion/GI: abdominal pain indigestion/reflux (triggers_____) burping diarrhea constipation bloating frequent vomiting choking on foods (specify which ones: _____)

Feeding and nutrition:
Do you have concerns about you child's weight or height? ☐ wt loss ☐ wt gain ☐ too heavy ☐ too skinny
Does your child have difficulty feeding? ☐ No ☐ Yes explain: _____
Does your child avoid or refuse particular foods:
☐ Milk ☐ Egg ☐ Wheat ☐ Soy ☐ Peanut ☐ Tree nut ☐ Fish ☐ Shellfish
other: _____

Does your child avoid certain textures of foods? ☐ Soft/mushy ☐ Crunchy ☐ Bolus foods (breads)

Does your child cough or gag when eating or drinking? ☐ Liquids ☐ Solids Other:_____

Genitourinary: wetting bed frequent urination excessive thirst

Muscles/Bones: joint pain back pain muscle aches muscle weakness fractures

Blood/Lymph: anemia past lymphoma or cancer swollen nodes autoimmune disease
recurrent blood infections other infections:_____

Neurologic/Psychiatric: concentration problems seizures coordination problems
anxious/worried depressed/tearful stressed hyperactive trouble at school mood swings

Safety: refuse to wear seat belts refuse to use booster seat in car (if appropriate)
refuse to wear helmet with biking/skateboarding/skiing if adolescent – use drugs or smoke

Other things you consider pertinent:_____
_____
_____

Medications:

Asthma/COPD Inhalers (circle strength you are using, fill in frequency of use):

Advair Diskus (100/50 250/50 500/50) HFA (45/21 115/21 230/21) AirDuo (55/14 113/14 232/14)
Breo Ellipta (100/5 200/5) Symbicort (80/4.5 160/4.5) Dulera (50/5 100/5 200/5)
QVAR (40 80) Pulmicort (90 180) Asmanex HFA (100 200) Asmanex Twist (110 220) Alvesco (80 160)
Flovent (44 110 220) Armon (55 113 232) Arnuity Ellipta (100 200)
Anoro Ellipta 62.5/24 Bevespi 62.5/4.8 Stiolto 2.5/2.5 Utibron 27.5/15.6 Trelegy 11/62.5/25
Seebri Incruse Ellipta Spiriva Handihaler Spiriva Respimat (1.25 2.5) Tudorza Atrovent Combivent
Arcapta Neohaler Serevent Diskus Striverdi Respimat # puffs: _____ # times daily:_____ as needed

Proair (HFA/RespiClick) Proventil Ventolin Albuterol (HFA/nebs) Xopenex/levalbuterol (HFA/nebs)
once daily twice daily before exercise as needed (*circle all that apply*)
Other inhalers (including Primatene Mist):_____

Nasal treatments (circle kind and how used):

Flonase/fluticasone Nasacort/triamcinolone Nasonex/mometasone flunisolide daily 2 x daily as needed
Astepro or Astelin (generic for azelastine) Patanase/olopatadine Atrovent/ipratropium (0.03% 0.06%)
Afrin 4-Way oxymetazoline Wilson's (gentamycin) solution Mupirocin irrigations
Nasal irrigations Bottle/Neti pot (with fluticasone, mometasone of budesonide?) once daily as needed

Oral Allergy medications (circle dose):

Singulair/montelukast 4 mg 5 mg 10 mg daily seasonally as needed or tried, but didn't seem to work
Allegra/fexofenadine (30 60 180 mg) Zyrtec/cetirizine (2.5 5 10 mg) Claritin/loratadine (2.5 5 10 mg)
Benadryl/diphenhydramine 25 mg as needed as prescribed by pediatrician: 12.5 mg/5 ml_____
Sudafed/pseudoefedrine Hydroxyzine/Atarax/Vistaril scheduled before bed as needed

Skin treatments (topical prescription steroids & over-the-counter – even ones you rarely use):

Hydrocortisone (2.5% 1%) Triamcinolone 0.1% Mometasone 0.1% Protopic/tacrolimus (0.1% 0.03%)
Elidel/pimecrolimus Eucrisa/crisaborole Other:_____

Over the counter (PLEASE CIRCLE IF EVEN RARELY TAKEN):

Advil/Ibuprofen Aleve/naprosyn aspirin Tylenol/acetaminofen
Prilosec/omeprazole Prevacid/lansoprazole esomeprazole pantoprazole Pepcid/famotidine
Vitamin D (daily) 400 IU 800 IU 1000 IU 2000 IU 4000 IU 5000 IU other: _____

Prescription medications for other conditions (continue on back side if needed) :

_____ mg ___# times daily _____ mg ___# times daily
_____ mg ___# times daily _____ mg ___# times daily
_____ mg ___# times daily _____ mg ___# times daily
Other biologic injections/infusions at home or in infusion center:_____