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Pediatric 1st Visit History Sheet (Birth-17 years)

Child's Name: _____

Child's Age: _____

Person Completing Form: _____

Date: _____

Referred by: _____

- Thank you very much for the time and effort put into filling out this form. Please complete this questionnaire before seeing the doctor. It will greatly help us learn more about your child's allergies and help us get the most out of their appointment.
- Antihistamine medications (Claritin, Clarinex, Zyrtec, Xyzal, Allegra, Benadryl, Atarax, Contac, Tylenol PM or Allergy, etc.) may interfere with skin tests for specific allergies; each antihistamine has a specific time frame for which it needs to be discontinued prior to skin testing. The office nursing staff can assist you with this.
- If your child has a holding chamber/spacer for inhaled medication, please bring it to their appointment.

Reason for Today's Visit (please describe in your own words):

1) Nose Symptoms or Eye Symptoms (when not sick)?

No (skip to next section), Yes (please fill out below)

- sneezing, nasal itchiness, throat itchiness, nasal congestion,
 decreased sense of smell, headaches, nasal pressure,
 post nasal drip, nasal discharge (color _____, thickness _____),
 mouth breathing, snoring,
 red eyes, itchy eyes, eye drainage (color _____, thickness _____), eye stinging,
 eye burning, vision changes, light sensitivity, foreign body sensation of eye,
 stringy discharge from eye

Triggers: house dust, cat, dog, temperature/humidity changes, smoke, odors, eating,
 exercise, aspirin, nonsteroidal anti-inflammatory drugs, betablockers,
 foods, menstrual cycle

How long has this been a problem? _____

Timing: year round, seasonal (winter, spring, summer, fall)

Frequency: symptoms less than 4 days per week or less than 4 weeks duration

symptoms present for more than 4 days per week and present for more than 4 weeks

symptoms present for 12 or more weeks

Function: symptoms do not affect sleep, work, school, sports, daily activities, playing.

symptoms affect: sleep, work or school, sports, daily activities, playing

Medications used for this problem:

Antihistamines: Benadryl(diphenhydramine), Claritin(loratadine), Clarinex(desloratadine),
 Zyrtec(cetirizine), Xyzal(levocetirizine), Allegra(fexofenedine), other _____

Nasal Sprays: Nasonex(mometosone), Rhinocort(budesonide), flonase(fluticasone),
 Nasocort(triamcinolone), Omnaris(Ciclesonide), Veramyst(fluticasone furoate),
 other nasal steroids _____, Astelin(azelastine),
 Nasal Atrovent(ipratropium bromide), Afrin, antibiotics,

Eye Drops: Patanol/Pataday(olopatadine), Zaditor(ketotifen), Alocril(nedocromil),
 Alomide(lodoxamide), Alamast(pemirolast potassium) Optivar(azelastine),
 Elestat(epinastine), Crolom/Opticrom(cromolyn), Acular(ketorolac), steroid drops,
 other _____

Oral steroids: no, yes Name: _____

Medications used for nasal or eye symptoms:

Which of the above medications were helpful? _____

2) Respiratory/Breathing Symptoms (Coughing/Wheezing/Shortness of Breath/Chest Tightness)? Day time/nighttime or with activity

No (skip to next section), Yes (please fill out below)

coughing/ wheezing/ shortness of breath/ chest tightness

Age of onset _____

Timing: day time, nighttime, with activity (crying, laughing, running, etc.)

Day time Frequency: never, 2 or less times/week(mi), more than 2 times/week but less than once/day(mp), daily symptoms or daily use of albuterol/xopenex(modp), continual day time symptoms or limited physical activity or frequent daily exacerbations(sp)

Night time frequency: never, 2 or less times per month,

more than 2 times a month, more than once a week, frequent nighttime symptoms

How long has this been a problem? _____

Triggers: cats, dogs, house dust, outdoors(seasonal? yes, no), colds, smoke, odors,
 cold, exercise, eating, stress, temp changes, aspirin, nonsteroidal anti-inflammatory drugs,
 betablockers, foods, , menstrual cycle

Number of missed days of school this year for these symptoms: _____

Number of times treated with oral steroids this year: _____, in lifetime: _____

Number of emergency room visits in last year for these symptoms: _____, in lifetime: _____

Number of hospitalizations in last year for these symptoms: _____, in lifetime: _____

Ever admitted to the ICU? no, yes (Intubated? no, yes)

Medications Used for this problem:

Proventil/Proair/Ventolin(albuterol), Maxair(pirbuterol),
 Xopenex(levabuterol), Atrovent(ipratropium bromide), Flovent(fluticasone),
 Pulmicort(budesonide), Advair(fluticasone/salmeterol), Symbicort(budesonide/formoterol),
 Asmanex(mometosone), Qvar(beclomethasone), Intal(cromolyn), Tilade(nedocromil),
 Spiriva(tiotropium), Xolair(omalizumab), oral steroids, other _____

Medications used for respiratory/breathing symptoms:

Which of the above medications were helpful? _____

3) Reaction to Foods?

No (skip to next section), Yes (please fill out for each food separately below) If your child reacted to more than three foods, please print out or ask for an additional sheet.

<p>Suspected food: _____</p> <p>Route of Contact: <input type="checkbox"/> ate, <input type="checkbox"/> inhaled, <input type="checkbox"/> contact with eye or skin</p> <p>Symptoms: Skin (<input type="checkbox"/> hives, <input type="checkbox"/> eczema, <input type="checkbox"/> itching, <input type="checkbox"/> swelling [<input type="checkbox"/> extremities, <input type="checkbox"/> face, <input type="checkbox"/> lips], <input type="checkbox"/> flushing, <input type="checkbox"/> sweating)</p> <p style="padding-left: 40px;">Gastrointestinal (<input type="checkbox"/> nausea, <input type="checkbox"/> belly pain, <input type="checkbox"/> vomiting, <input type="checkbox"/> diarrhea, <input type="checkbox"/> tongue swelling),</p> <p style="padding-left: 40px;">Respiratory (<input type="checkbox"/> sneezing, <input type="checkbox"/> runny nose, <input type="checkbox"/> eye redness, <input type="checkbox"/> eye itchiness, <input type="checkbox"/> coughing, <input type="checkbox"/> wheezing, <input type="checkbox"/> hoarseness, <input type="checkbox"/> Shortness of breath),</p> <p style="padding-left: 40px;">Cardiovascular/Neurologic (<input type="checkbox"/> irritability, <input type="checkbox"/> dizziness, <input type="checkbox"/> loss of consciousness), <input type="checkbox"/> headache</p> <p>Time between eating and reaction: <input type="checkbox"/> immediate, <input type="checkbox"/> ___ minutes, <input type="checkbox"/> ___ hours, <input type="checkbox"/> ___ days</p> <p>Associated with activity or exercise (<input type="checkbox"/> yes, <input type="checkbox"/> no)</p> <p>Number of times reaction has occurred: _____</p> <p>Smallest amount of food needed to cause reaction _____, Largest amount of food observed _____</p> <p>Most recent reaction _____, Last exposure _____</p> <p>Is the food being avoided? <input type="checkbox"/> yes, <input type="checkbox"/> no: Do you read labels to avoid the implicated food? <input type="checkbox"/> yes, <input type="checkbox"/> no</p> <p>Treatment in past _____, Response to treatment _____</p> <p>Active Epi pen/Twinject? <input type="checkbox"/> yes, <input type="checkbox"/> no Dose: <input type="checkbox"/> Senior (0.3mg) <input type="checkbox"/> Junior (0.15mg)</p> <p>Expiration Date: _____</p>
<p>Suspected food: _____</p> <p>Route of Contact: <input type="checkbox"/> ate, <input type="checkbox"/> inhaled, <input type="checkbox"/> contact with eye or skin</p> <p>Symptoms: Skin (<input type="checkbox"/> hives, <input type="checkbox"/> eczema, <input type="checkbox"/> itching, <input type="checkbox"/> swelling [<input type="checkbox"/> extremities, <input type="checkbox"/> face, <input type="checkbox"/> lips], <input type="checkbox"/> flushing, <input type="checkbox"/> sweating)</p> <p style="padding-left: 40px;">Gastrointestinal (<input type="checkbox"/> nausea, <input type="checkbox"/> belly pain, <input type="checkbox"/> vomiting, <input type="checkbox"/> diarrhea, <input type="checkbox"/> tongue swelling),</p> <p style="padding-left: 40px;">Respiratory (<input type="checkbox"/> sneezing, <input type="checkbox"/> runny nose, <input type="checkbox"/> eye redness, <input type="checkbox"/> eye itchiness, <input type="checkbox"/> coughing, <input type="checkbox"/> wheezing, <input type="checkbox"/> hoarseness, <input type="checkbox"/> Shortness of breath),</p> <p style="padding-left: 40px;">Cardiovascular/Neurologic (<input type="checkbox"/> irritability, <input type="checkbox"/> dizziness, <input type="checkbox"/> loss of consciousness), <input type="checkbox"/> headache</p> <p>Time between eating and reaction: <input type="checkbox"/> immediate, <input type="checkbox"/> ___ minutes, <input type="checkbox"/> ___ hours, <input type="checkbox"/> ___ days</p> <p>Associated with activity or exercise (<input type="checkbox"/> yes, <input type="checkbox"/> no)</p> <p>Number of times reaction has occurred: _____</p> <p>Smallest amount of food needed to cause reaction _____, Largest amount of food observed _____</p> <p>Most recent reaction _____, Last exposure _____</p> <p>Is the food being avoided? <input type="checkbox"/> yes, <input type="checkbox"/> no: Do you read labels to avoid the implicated food? <input type="checkbox"/> yes, <input type="checkbox"/> no</p> <p>Treatment in past _____, Response to treatment _____</p> <p>Active Epi pen/Twinject? <input type="checkbox"/> yes, <input type="checkbox"/> no Dose: <input type="checkbox"/> Senior (0.3mg) <input type="checkbox"/> Junior (0.15mg)</p> <p>Expiration Date: _____</p>
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4) Eczema/Dry, itchy skin

No (skip to next section), Yes (please fill out below)

Age of onset: _____

Areas affected: face, elbows, knees, creases of arms,
 creases of legs belly chest back

Symptoms: itching, hives, redness, oozing, pale face, red face, Lightening of skin,
 Darkening of skin, darkening around the eyes, creases/folds under the eyes, chicken skin

How long has this been a problem? _____

Triggers: food, emotion, environmental contacts (_____), sweating, wool,
 soaps/detergents, illness, menstrual cycle

History of Skin infections no, yes (Required: topical antibiotics, oral antibiotics, IV antibiotics)

All Medications used for this problem including creams used for skin

Name	Strength/Dose	Started	Last used	Frequency used	Any Help?
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Bathing: no, yes: (# _____ times a week, length of bath: _____ minutes)

Types of Moisturizer used: _____ :# _____ times a day

Soaps used _____ Shampoo used _____

Detergent used _____ Fabric softner: no, yes

5) Reaction to Insect Sting: Any symptoms other than local pain, redness or swelling?

No (skip to next section), Yes (please fill out below)

Skin (swelling involving large area, skin findings not at location of the sting)

Gastrointestinal (nausea, belly pain, vomiting, diarrhea, tongue swelling),

Respiratory (sneezing, runny nose, eye redness, eye itchiness, coughing, wheezing,
 hoarseness, Shortness of breath),

Cardiovascular/Neurologic (irritability, dizziness, loss of consciousness), headache

Treatment in past _____

Response to treatment _____

Date of Last sting _____

Active Epi pen/Twinject? yes, no Dose: Senior (0.3mg) Junior (0.15mg)

Expiration Date: _____

6) Hives (itchy, red, raised welts) or Giant Swelling:

No (skip to next section), Yes (please fill out below)

Possible Triggers: foods, drugs, latex, stings, heat, exercise, sweating,

cold, pressure on skin, scratching, sunlight, other triggers: _____

Number of Episodes: _____

Date of Last Episode: _____

Do individual hives last more than 24 hours? no, yes

Any bruising on skin when hives heal? no, yes

7) Reflux/Heartburn Symptoms:

No (skip to next section), Yes (please fill out below)

- Frequent spitting up/vomiting, sour taste in mouth, bad breath, heartburn,
- back arching, coughing while/soon after eating/drinking

Medications Used: _____

8) Medication/Latex Allergies:

No (skip to next section), yes (please specify: see below)

Reaction to Medication	Description of reaction	Approximate date of last reaction
<input type="checkbox"/> penicillins		
<input type="checkbox"/> sulfa		
<input type="checkbox"/> other antibiotics		
<input type="checkbox"/> aspirin		
<input type="checkbox"/> pain relievers (Motrin/Advil/Aleve, etc)		
<input type="checkbox"/> sedatives		
<input type="checkbox"/> corticosteroids		
<input type="checkbox"/> nose sprays/drops		
<input type="checkbox"/> antihistamines		
<input type="checkbox"/> contrast/X-ray dye		
<input type="checkbox"/> latex		
<input type="checkbox"/> other		

Review of Systems:

(please indicate if your child is **currently** experiencing any of the following)

General: <input type="checkbox"/> none, <input type="checkbox"/> fever, <input type="checkbox"/> weight loss, <input type="checkbox"/> change in activity	Genital/Urinary: <input type="checkbox"/> none, <input type="checkbox"/> frequent urination, <input type="checkbox"/> pain with urination, <input type="checkbox"/> blood in urine
Endocrine: <input type="checkbox"/> none, <input type="checkbox"/> weight loss, <input type="checkbox"/> weight gain	Skin: <input type="checkbox"/> none, <input type="checkbox"/> rashes
Eyes: <input type="checkbox"/> none, <input type="checkbox"/> crossing, <input type="checkbox"/> pain, <input type="checkbox"/> redness, <input type="checkbox"/> drainage	Neuro: <input type="checkbox"/> none, <input type="checkbox"/> seizures, <input type="checkbox"/> loss of consciousness
Ear: <input type="checkbox"/> none, <input type="checkbox"/> Ear pain, <input type="checkbox"/> drainage, <input type="checkbox"/> hearing loss Nose: <input type="checkbox"/> none, <input type="checkbox"/> drainage, <input type="checkbox"/> discharge, <input type="checkbox"/> sinusitis Throat: <input type="checkbox"/> none, <input type="checkbox"/> tooth pain, <input type="checkbox"/> sore throat, <input type="checkbox"/> hoarseness	GI: <input type="checkbox"/> none, <input type="checkbox"/> feeding problems, <input type="checkbox"/> appetite changes, <input type="checkbox"/> vomiting, <input type="checkbox"/> diarrhea, <input type="checkbox"/> constipation, <input type="checkbox"/> blood in the stool, <input type="checkbox"/> abdominal pain
Respiratory: <input type="checkbox"/> none, <input type="checkbox"/> cough, <input type="checkbox"/> wheezing, <input type="checkbox"/> pauses in breathing, <input type="checkbox"/> blueness, <input type="checkbox"/> difficulty breathing	Musculoskeletal: <input type="checkbox"/> none, <input type="checkbox"/> joint swelling, <input type="checkbox"/> tenderness, <input type="checkbox"/> weakness
Cardiac: <input type="checkbox"/> none, <input type="checkbox"/> murmurs, <input type="checkbox"/> chest pain, <input type="checkbox"/> sweating with feeds	Psych: <input type="checkbox"/> none, <input type="checkbox"/> mood changes, <input type="checkbox"/> sleep problems
Hematologic/lymph nodes: <input type="checkbox"/> none, <input type="checkbox"/> bleeding, <input type="checkbox"/> anemia, <input type="checkbox"/> yellow skin or eyes, <input type="checkbox"/> swollen glands	

PLEASE FILL OUT ALL OF THE FOLLOWING

All Current Medications:

(please include over the counter, herbal remedies, eye drops, creams, nasal sprays, inhalers):

Name Dose Frequency

Past Medical History:

Other medical problems:(Please list) _____

Birth History: Full Term? yes, no (how many weeks? _____)

Method of Delivery: vaginal, caesarean (reason: _____)

Complications? no, yes (please specify: _____)

NICU stay? no, yes (length of time: _____)

Diet History: Breast fed? no, yes (length of time in months: _____)

Formula fed? no, yes (name of formula: _____)

(Age when introduced: _____)

Please list all foods that are currently avoided: _____

Infectious History:

Number of lifetime (bronchiolitis _____, croup _____)

Last (bronchiolitis _____, croup _____)

Number of lifetime (ear infections _____, pneumonias _____, sinusitis _____)

Number of infections/year (ear _____, pneumonia _____, sinusitis _____)

Last infection (ear _____, pneumonia _____, sinusitis _____)

History of none of the following: (bone infections, brain infection, skin infection,

blood infection, urinary tract infection, herpes infections, warts, trouble with live vaccines, chronic diarrhea)

Past Surgical History:(Please list all surgeries) _____

Immunizations: up to date yes, no

Any reaction? No, Yes (please specify: _____)

Date of last flu shot: _____

Social History/Environmental History:

(The questions related to the child's home also apply to other indoor environments where the child spends time, including school, daycare, car, school bus, work, and recreational facilities)

Home Characteristics: Type of dwelling: House, Apartment, Condo, Dormitory, Mobile/Motorhome

Age of dwelling: _____ years, Years of occupancy _____

Heating system: forced air(filter type _____), baseboard, hot water, radiator,
wood stove, kerosene heater

Cooling system: central air(filter type _____), room air conditioners, fans,
open windows, window fan

Filters: none, HEPA, ionizing, other _____, location of filters: _____

Mold Exposure

Mold/mildew in the home? no, yes (location: _____)

Water damage in the home? no, yes (location: _____)

Are humidifiers used? no, yes (location: _____)

Are dehumidifiers used? no, yes (location: _____)

Dust Mite Exposure

Stuffed animals? no, yes(location and number: _____)

Carpets? no, yes (wall to wall, area: locations _____)

Curtains? no, yes(location: _____)

Vacuum? no, yes (Type: HEPA filtered vacuum, standard vacuum, wet/dry vacuum)

Frequency of Vacuuming/Mopping? daily, weekly, 2x/month, monthly

Animal/Pest Exposure

Pets: Any contact with animals/pets? no, yes

Frequency of exposure: Daily, Weekly, Monthly, Rarely

Types of Animals: _____, _____, _____, _____, _____

Location: home, relative, school, other: _____

Location in home: _____

Can they go in the child's bedroom? no, yes

Pests: cockroaches, ladybugs/ladybird beetles, mice, Location in home: _____

Child's Room

Carpets, pets, pests, stuffed animals, curtains, filters

Pillows used by child: Feather/Down, foam, rubber, synthetic, encasement (age in years _____)

Bed Mattress: conventional, vinyl, air, water: Age in years _____

When are bed linens washed/changed? daily, weekly, 2x/month, monthly, less than once a month

Smoke Exposure

Smoking in the home? no, yes

Anyone in contact with the child smokes? no, yes (amount of time exposed _____)

Does your child smoke? no, yes (age when 1st smoked _____)

Indoor/Outdoor Pollution/Chemicals

Do any people who have contact with the child have exposure to dusts, chemicals, animals, or occupational hazards? no, yes(Type of exposure: _____)

Does your child or another family member have a hobby that uses materials that are toxic or give off fumes? no, yes(Type of exposure: _____)

How close do you live to major roadways? _____ Location (town): _____

Gas stove? no, yes(pilot light? no, yes)

New carpets, paint, floor refinishing, or other changes at your house in the past year? no, yes

Family History of Allergy:

	Eyes	Hay-fever or Sinusitis	asthma	food allergies	Eczema	Hives or Swelling	Recurrent Infections
Mother							
Father							
Siblings							
Maternal Grandparents							
Paternal Grandparents							
Other relatives							

Other Family History/Illnesses:

	Age	Illness	If deceased, cause of death
Mother			
Father			
Siblings			
Maternal Grandparents			
Paternal Grandparents			

I certify that the above information is complete and accurate.

Signature: _____ Date: _____

Relationship to patient: _____

I certify that I have reviewed the above information with the patient.

Physician Signature: _____ Date: _____