PEDIATRIC ASSOCIATES
Caring for Infants, Children and Adolescents Since 1955

Save time during your child's first visit with Dr. Malka. Print and fill out this Patient Questionnaire, then bring it with you to your child's office visit. Please present the form at check-in.

ALLERGY/IMMUNOLOGY PATIENT QUESTIONNAIRE

Patient Name_____ Today's Date ____/____/_____

Date of Birth ____/____/_____ Age _____ Sex ☐ Male ☐ Female

Race (mark one only) ☐ American Indian ☐ Asian ☐ Black or African American

☐ Caucasian ☐ Hispanic ☐ Jewish Ashkenazi ☐ Jewish Sephardic ☐ Middle Eastern/Arabic

☐ Other (specify) _____ ☐ Mixed (specify) _____

Parents' marital status ☐ Married ☐ Divorced ☐ Separated ☐ Single ☐ Unknown

☐ Other (specify): _____

Child lives with ☐ Both parents ☐ Father ☐ Mother ☐ Other (specify):_____

PHYSICIAN AND PHARMACY INFORMATION

Primary Referring Physician

Name _____
Address _____
_____
_____
Phone _____
Fax _____
Email _____

PHARMACY INFORMATION

Name _____
Address _____
_____
_____
Phone _____
Fax _____
Email _____

Mail Order Pharmacy

Name _____
Address _____
_____
_____
Phone _____
Fax _____

Alternate Pharmacy

Name _____
Address _____
_____
_____
Phone _____
Fax _____

Briefly describe the reason for your visit:

PAST MEDICAL HISTORY

Length of pregnancy: ☐ Full-term ☐ Early (# of weeks) _____

Birth weight ___ lbs. _____ oz

Type of delivery: ☐ Vaginal ☐ Planned C-section ☐ Emergency C-section

Were there problems with the pregnancy?

☐ No ☐ Yes (specify) _____

Were there problems with labor or delivery?

☐ No ☐ Yes (specify) _____

Did your child have breathing problems at birth?

☐ No ☐ Yes (specify) _____

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

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

Did your child have colic? ☐ No ☐ Yes

Your child's growth pattern: ☐ Normal ☐ Rapid ☐ Slow

Your child's development rate (sitting, crawling, walking, talking):

☐ Normal ☐ Delayed

Are immunizations up-to-date? ☐ Yes ☐ No (explain):_____

Has your child had any of the following illnesses?

	No	Yes		
Chicken pox	☐	☐		
RSV	☐	☐		
	No	**Yes**	**Age of Onset**	**Number of Times**
Ear infections	☐	☐	_____	_____
Sinus infections	☐	☐	_____	_____
Pneumonia	☐	☐	_____	_____
Croup	☐	☐	_____	_____
Other Illnesses	☐	☐ (specify)_____		

Hospitalizations? ☐ No ☐ Yes

Month/Year

_____ Reason: _____

_____ Reason: _____

_____ Reason: _____

_____ Reason: _____

Surgeries? ☐ No ☐ Yes **Year**

☐ Ear Tube(s) _____

☐ Tonsillectomy _____

☐ Adenoidectomy _____

☐ Sinus Surgery _____

☐ Other:_____ _____

☐ Other:_____ _____

ALLERGY HISTORY

Is your child allergic to foods?

☐ No

☐ Yes → Mark all that apply and specify reaction:

- ☐ Milk: _____
- ☐ Egg: _____
- ☐ Soy: _____
- ☐ Wheat: _____
- ☐ Peanuts: _____
- ☐ Tree nuts: _____
- ☐ Shellfish: _____
- ☐ Fish: _____
- ☐ Other (specify): _____

_____

_____

Does the child avoid or refuse particular foods?

☐ No

☐ Yes → Mark all that apply:

- ☐ Milk: _____
- ☐ Egg: _____
- ☐ Soy: _____
- ☐ Wheat: _____
- ☐ Peanuts: _____
- ☐ Tree nuts: _____
- ☐ Shellfish: _____
- ☐ Fish: _____
- ☐ Other (specify): _____

_____

_____

	No	Unknown	Yes
Is your child allergic to:			
Animals?	☐	☐	☐ ☐ Cats ☐ Dogs ☐ _____
Medications?	☐	☐	☐ Specify: _____
Insect stings?	☐	☐	☐ Specify: _____
Does your child have:			
Atopic dermatitis/eczema?	☐	☐	☐
Frequent hives or swelling?	☐	☐	☐
Nasal allergies?	☐	☐	☐ When? Spring ☐ Summer ☐ Fall ☐ Winter☐
Eye allergies?	☐	☐	☐ When? Spring ☐ Summer ☐ Fall ☐ Winter☐

FAMILY MEDICAL HISTORY

Child's Father: Age _____ years Occupation: _____
Does he have any of the following conditions? (mark all that apply)

☐ No allergies ☐ Allergy to animals _____ ☐ Asthma
☐ Food allergy _____ ☐ Hay fever ☐ Insect sting allergy
☐ Latex allergy ☐ Medication allergy_____ ☐ Eczema

Child's Mother: Age _____ years Occupation: _____
Does she have any of the following conditions? (mark all that apply)

☐ No allergies ☐ Allergy to animals _____ ☐ Asthma
☐ Food allergy_____ ☐ Hay fever ☐ Insect sting allergy
☐ Latex allergy ☐ Medication allergy_____ ☐ Eczema

Child's Brothers/Sisters? Number: _____

Sibling 1: Age _____ years ☐ Female ☐ Male
Does he/she have any of the following conditions? (mark all that apply)

☐ No allergies ☐ Allergy to animals _____ ☐ Asthma
☐ Food allergy_____ ☐ Hay fever ☐ Insect sting allergy
☐ Latex allergy ☐ Medication allergy_____ ☐ Eczema

Sibling 2: Age _____ years ☐ Female ☐ Male
Does he/she have any of the following conditions? (mark all that apply)

☐ No allergies ☐ Allergy to animals _____ ☐ Asthma
☐ Food allergy_____ ☐ Hay fever ☐ Insect sting allergy
☐ Latex allergy ☐ Medication allergy_____ ☐ Eczema

Sibling 3: Age _____ years ☐ Female ☐ Male
Does he/she have any of the following conditions? (mark all that apply)

☐ No allergies ☐ Allergy to animals _____ ☐ Asthma
☐ Food allergy_____ ☐ Hay fever ☐ Insect sting allergy
☐ Latex allergy ☐ Medication allergy_____ ☐ Eczema

Does any family member have cystic fibrosis? ☐ No ☐ Yes

Does any family member have any other type of lung disease? ☐ No ☐ Yes

Specify _____

HOME ENVIRONMENTAL HISTORY

Type (house, etc): _____ Age: _____ Yrs Yrs @ residence _____ Location: _____

Basement?	☐ No	☐ Yes	
Finished?	☐ No	☐ Yes	
Air Condition?	☐ No	☐ Yes	☐ Central ☐ Window (room)
Air Purification/Filter?	☐ No	☐ Yes	
Carpet?	☐ No	☐ Yes	☐ wall-to-wall ☐ bedrooms
Feather Pillows?	☐ No	☐ Yes	
Pillow & Mattress Encasings?	☐ No	☐ Yes	

Pets?

☐ Dogs #_____	☐ Indoor	☐ Outdoor	☐ Indoor/Outdoor	☐ In Bedroom
☐ Cats #_____	☐ Indoor	☐ Outdoor	☐ Indoor/Outdoor	☐ In Bedroom
☐ Birds #_____	☐ Indoor	☐ Outdoor	☐ Indoor/Outdoor	☐ In Bedroom
☐ Other #_____	☐ Indoor	☐ Outdoor	☐ Indoor/Outdoor	☐ In Bedroom

Are there smokers in the residence?

☐ No ☐ Yes ☐ Father ☐ Mother ☐ Relatives ☐ Only visitors ☐ Only outside

Does your child have any exposure to the following?

☐ Mold ☐ Water Damage ☐ Leaking Roof
☐ Dirty Humidifier
☐ Other Exposures of Concern:
☐ None of the above

Does your child have any exposure to the following activities?

☐ Sauna ☐ Steam room ☐ Gardening ☐ Compost Pile
☐ Hot Tub ☐ Indoor ☐ Outdoor
☐ None of the above

SOCIAL HISTORY

1. What grade is your child in? _____ ☐ Not applicable
2. Does your child attend daycare? ☐ No ☐ Yes
   a. How many days per week:_____
3. Is your child home-schooled? ☐ No ☐ Yes
4. Do you have difficulty getting your child to take medications? ☐ No ☐ Yes
5. Does your child have problems in school with learning or with teachers? ☐ No ☐ Yes
6. Is your child in special education classes? ☐ No ☐ Yes
7. Has your child been in counseling? ☐ No ☐ Yes

HEALTH PROBLEMS (REVIEW OF SYSTEMS)

If needed, please add additional information regarding any positive responses at the bottom of this section.

General Symptoms	☐ Fatigue ☐ Fever/chills ☐ Trouble sleeping ☐ Loss of appetite	☐ None
Eyes	☐ Blurred vision ☐ Burning ☐ Cataracts ☐ Dry Eyes ☐ Frequent blinking ☐ Watery eyes ☐ Itching ☐ Lazy eye ☐ Near-sighted ☐ Far-sighted ☐ Wears glasses ☐ Redness ☐ Swelling	☐ None
Ears, Nose, & Throat	☐ Change in sense of smell ☐ Dry mouth ☐ Hearing loss ☐ Sore throat ☐ Ear pain ☐ Hoarseness/change in voice ☐ Itchy nose ☐ Sneezing ☐ Mouth breathing ☐ Snoring ☐ Mouth sores ☐ Nasal congestion ☐ Nasal drainage ☐ Nasal polyps ☐ Nosebleeds ☐ Post-nasal drip ☐ Sinus congestion ☐ Stridor ☐ Throat tightness	☐ None
Speech	☐ Delay/Impediment ☐ Slurred ☐ Stuttering	☐ None
Heart	☐ Chest pain ☐ Dizziness ☐ Murmurs ☐ Fainting spells ☐ Irregular heartbeat ☐ Palpitations	☐ None
Lungs	☐ Cough-nonproductive/dry ☐ Cough productive (phlegm) ☐ Cough at night ☐ Coughing up blood ☐ Chest tightness ☐ Frequent bronchitis/chest colds ☐ Wheezing ☐ Shortness of breath during day ☐ Shortness of breath during night ☐ Shortness of breath with exercise or vigorous play ☐ Low oxygen levels	☐ None
Gastrointestinal (GI)	☐ Abdominal pain/stomach ache ☐ Indigestion ☐ Regurgitation/spitting up ☐ Heartburn ☐ Acid taste in mouth ☐ Constipation ☐ Diarrhea ☐ Nausea ☐ Vomiting ☐ Burping ☐ Gassiness ☐ Bloating ☐ Bloody stool	☐ None
Feeding and Nutrition	☐ Weight loss ☐ Poor weight gain ☐ Overweight ☐ Too short ☐ Too thin ☐ Difficulty feeding ☐ Loss of appetite ☐ Choking on food/drink ☐ Trouble swallowing ☐ Avoidance of certain food textures (specify):_____	☐ None
Genitourinary	☐ Bedwetting ☐ Wetting pants ☐ Encoporesis (soiling pants) ☐ Frequent urination ☐ Painful urination ☐ Menses: Onset: ____ years	☐ None
Muscles and	☐ Fractures ☐ Back pain ☐ Joint pains ☐ Joint swelling	☐ None

Bones ☐ Muscle pain ☐ Muscle weakness

Neurological ☐ Concentration problems ☐ Difficulty walking ☐ Headaches ☐ None
☐ Numbness ☐ Tremors ☐ Seizures ☐ Weakness
☐ Excessive daytime sleepiness ☐ Insomnia
☐ Nonrestorative sleep (not rested after)
☐ Restless sleep (frequent change in position)
☐ Stopping breathing (apnea)

Skin ☐ Rashes ☐ Eczema ☐ Skin infections ☐ Hives/welts ☐ None
☐ Itching ☐ Lumps ☐ Hair Loss

Hematology (Blood)/Lymphoid ☐ Anemia ☐ Easy bruising ☐ Bleeding tendency ☐ None
☐ Enlarged Lymph Nodes

Psychological ☐ Anxious/worried ☐ Depressed/tearful ☐ Hyperactive ☐ None
☐ Mood swings ☐ Panic attacks
☐ Stressed (reason):_____

Additional Information: _____

MEDICATIONS

Does you child take any vitamins, minerals, or supplements? ☐ No ☐ Yes

Does your child take medications? ☐ No ☐ Yes → fill in table below:

Medication Name	Dose	Route	How Often	Description
Vitamins/Supplements				
Steroid Inhalers				
☐ Asmanex				white w/a pink bottom ring 7 counter (twisthaler)
☐ Flovent (Flow-Vent)				orange w/an orange cap (mdi)
☐ Pulmicort (Pull-Mih-Court)				white w/bottom brown ring in a turbuhaler or flexhaler or tube
☐ Pulmicort (Pull-Mih-Court)				respules containing liquid for nebulizer
☐ QVAR				brown or burgundy depending on dose w/gray cap

Medication Name	Dose	Route	How Often	Description
Fast-acting Inhalers				
☐ Albuterol (Al-Bew-Ter-All)				white w/white cap (mdi)
☐ Ventolin (Ven-Toe-Lin)				light blue w/dark blue cap & counter (mdi)
☐ Atrovent (At-Row-Vent)				clear w/green cap (mdi)
☐ Proair (Pro-Air)				red w/white cap (mdi)
☐ Proventil (Pro-Vent-Ill)				yellow w/orange cap (mdi)
☐ Maxair (Max-Air)				light blue (autohaler)
☐ Xopenex (Zo-Pin-Ex)				light blue w/red cap (mdi)
☐ Combivent				clear w/orange cap
☐ Primatene Mist				
Long-acting Bronchodilators				
☐ Spiriva (Spy-Reev-Ah)				oval device gray base w/green piercing button. Need to load pill into oval device (handihaler)
Combination Medications (Inhaled Steroid and Long Acting Bronchodilator)				
☐ Advair (Add-V-Air)				purple disc w/counter (diskus)
☐ Symbicort (Sim-By-Court)				red w/gray cap (mdi)
Leukotriene Modifying Agents				
☐ Singulair (Sing-Yule-Air)				pink or tan pill
☐ Accolate (Ac-Coal-Aid)				white pill
☐ Zyflo (Z-Eye-Flow)				white pill (big)
Oral Steroids				
☐ Prednisone, Deltasone, Medrol				white pill
☐ Orapred, Prelone, Pediapred				liquid
Antihistamines				
☐ Allegra				
☐ Benadryl				
☐ Hydroxyzine				
☐ Clarinex				
☐ Claritin				
☐ Xyzal				
☐ Zyrtec				
Nose Sprays				
☐ Saline/Saline Washes				
☐ Astelin/Astepro				
☐ Flonase				
☐ Nasacort AQ				
☐ Nasonex				

Medication Name	Dose	Route	How Often	Description
☐ Rhinocort AQ				
☐ Veramyst				
☐ Other:				
Eye Drops:				
☐ Patanol				
☐ Pataday				
Acid Reflux Medications				
☐ Zantac/Ranitidine				
☐ Prevacid				
☐ Prilosec				
☐ Nexium				
☐ Kapidex				
☐ Other:_____				
Skin Medications:				
☐ Ointments:				
☐ Moisturizers:				
Other Medications:				

_____ _____

Parent Signature Date

_____ _____

Clinician Signature Date