

ALLERGY & ASTHMA

CHILD GENERAL HISTORY

JEFFREY R. LEIPZIG, M.D. Print name: _____ Date of Birth: _____ Age _____

LAST

FIRST

MEDICATIONS:

List current prescription/ non-prescription medications (include vitamins, pain, relievers, and cold medicines). None

Name of Medication	Dose (Milligrams)	Frequency (times/ day)
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please identify other medications child has recently used: _____

ALLERGIES:

Has your child had a reaction to latex / adhesive tape? **YES NO**
 Has your child had hives, skin rash, breathing problems other reactions to medications? NO

Name of Medication	Describe Allergic Reaction
_____	_____
_____	_____
_____	_____

Are there other medications that your child does not tolerate due to unpleasant side effects? _____

REVIEW OF SYSTEMS: Please check YES or NO for the following questions, and CIRCLE all positive responses.

YES NO

1. Has your child had any serious reactions to stinging insects or drugs? (wheezing, passing out)			
2. Does your child's nose run, get stuffy, or itch? (not associated with colds)			
3. Has your child had a recent infections or prolonged infections?			
4. Unexplained fever or enlarged glands? (lymph nodes)			
5. Does your child awaken with frequent cough or shortness of breath at night?			
6. Does your child frequently cough with running/ playing?			
7. Has your child had heart problems? (palpitations, chest pain, murmur)			
8. Does your child have frequent constipation, diarrhea, or vomiting? Blood in stool?			
9. Does your child have difficulty eating, drinking, or swallowing?			
10. Does your child have problems with frequent or severe skin rashes?			
11. Does your child complain of headaches, or vision problems, use glasses?			
12. Does your child complain of pain or stiffness in joints or muscles?			
13. Does your child have recurrent sore throats?			
14. Does your child have problems with anemia or blood disorders?			
15. Has your child lost or gained weight recently for unexplained reasons?			
16. Does your child have spells, seizures or trouble moving an arm or leg?			
17. Does your child have depression or ADHD?			

PAST MEDICAL HISTORY:

BIRTH/FEEDING HISTORY: Circle and describe -Full Term: Preterm: _____ weeks Birth Weight: _____

Explain any complications during gestation or delivery _____

If breast fed how many months? _____ If bottle fed what formula? (circle) Similac Enfamil Isomil Prosobee

Did you need to change formula? Yes No Did your child suffer from colic? Yes No

At what age were solid foods introduced? (baby foods or table foods) Any problems? _____

Has your child received the following **IMMUNIZATIONS?** UP TO DATE Yes, Indicate the approximate year(s) given:

Measles <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Year _____	Influenza (flu) within last year <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Year _____
Mumps <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Year _____	Pneumococcal (for pneumonia) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Year _____
Rubella <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Year _____	Hepatitis B <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Year _____
Polio <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Year _____	Tetanus/ Diphtheria within last 10 yrs <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Year _____
HIB <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Year _____	Varicella (chicken pox) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Year _____

Has your child ever received a **BLOOD TRANSFUSION?** Yes No If yes, give year: _____

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Has your child ever been **HOSPITALIZED**? Yes No Describe: _____

Has your child your ever been to the **EMERGENCY ROOM**? Yes No Describe: _____

Indicate whether your child has ever had a **MEDICAL PROBLEM** and/ or **SURGERY** by checking the appropriate. If he/she has had surgery, indicate the approximate year(s). Circle the appropriate choice when multiple choices are listed in a question.

1. Abnormal growth or development		1. Eyes	
2. Abnormal chest x-ray(s)		2. Ears	
3. Pneumonia(s)		3. Nose	
4. Chicken Pox		4. Sinus	
5. Recurrent Otitis Media (ear infections)		5. Tonsils / Adenoids	
6. Recurrent Sinusitis (sinus infections)		6. Lungs	
7. Meningitis		7. Skin	
8. Skin problems		8. Thyroid	
9. Recurrent Hives		9. Heart Murmur	
10. Snoring		10. Esophagus or stomach	
11. Mouth breathing		11. Appendix	
12. Wheezing		12. Liver or Gallbladder (hepatitis)	
13. Persistent cough		13. Hernia	
14. Sneezing or itching		14. Kidney or Bladder	
15. Adverse reactions to immunizations		15. Bone, Joint, or Muscle	
16. Adverse reactions to foods		16. Back, Neck, or Spine	
17. Other		17. Brain	

SOCIAL HISTORY: Did / does your child attend daycare? YES NO

Who smokes? NONE (circle) Mom Dad Grandparents Baby-sitters How much? _____
 (If school aged) What grade is your child? _____ Days of daycare / school missed in past year due to illness _____
 In what activities does your child participate? _____

FAMILY HISTORY: Is your child adopted? YES NO Other members of family with allergies or asthma. (describe)
 Parents: _____ Siblings: _____

ENVIRONMENTAL HISTORY:

1. Does your child live with you in a home or an apartment? How long have they lived there?
2. What type of air conditioning? (central, window unit) Is child better in air conditioning?
3. What type of heating? (gas, electric, steam, wood burning, oil, etc.)
4. Do you have a dog? # ___ Inside / Outside In bedroom? Is the child worse around dogs?
5. Do you have a cat? # ___ Inside / Outside In bedroom? Is the child worse around cats?
6. Do you have any other indoor/outdoor animals? Is the child exposed to roaches?
7. What type of bedding does your child sleep on? (box spring / mattress, waterbed , etc.)
8. What type of pillow does your child have? (feather, foam, polyester)
9. Does your child use dust mite proof covers on bedding? <input type="checkbox"/> No How many stuffed animals?
10. What type of flooring is in bedroom? (carpet, area rug, hardwood, etc.)
11. Is there a damp basement?

Parent Comments / Concerns