# Allergy/Immunology New Patient Questionnaire

**Boston Children’s Hospital**

**ALLERGY/IMMUNOLOGY NEW PATIENT QUESTIONNAIRE**

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<tr>
<th>Name:</th>
<th>Date of Birth:</th>
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<tr>
<th>Pharmacy Name:</th>
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<th>Specialty Pharmacy Name:</th>
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I want to know:

My questions are:

I don’t want to leave without this (asthma or epinephrine action plan, prescription, etc):

### Review of Systems

Has your child been experiencing or diagnosed with any of the following? Please check any that apply:

#### General
- Feeling tired
- Fevers
- Chills or night sweats
- Poor weight gain
- Changes in appetite

#### Eyes
- Red or itchy eyes
- Blurred or altered vision
- Sensitivity to light

#### Ear/Nose/Throat
- Nasal congestion/snoring
- Post nasal drip/nasal discharge
- Ear or throat pain
- Nose bleeds
- Nasal polyps
- Loss of smell

#### Urinary
- Pain with urination
- Increased frequency of urination
- Urine infections

#### Lungs
- Cough
- Shortness of breath
- Wheezing

#### Heart
- Heart murmur
- Heart palpitations/irregular heartbeat
- Heart defects

#### Gastrointestinal
- Diarrhea
- Constipation
- Abdominal pain
- Nausea/Vomiting
- Acid reflux/heartburn
- Blood in stool
- Enlarged liver or spleen

#### Blood
- Easy bruising or bleeding
- Swollen glands
- Anemia
- Low white blood cell/platelet counts

#### Endocrine
- Excessive thirst
- Hot or cold intolerance
- Thyroid disorders
- Diabetes
- Delayed puberty

#### Skin
- Rash
- Birth marks or large moles

#### Bones/joints
- Muscle pain
- Joint pain/swelling

#### Neurologic
- Headaches
- Dizziness or lightheadedness
- Weakness/numbness/tingling
- Seizures

#### Psychiatric
- Hyperactivity disorder
- Depression or anxiety
- Sleep disturbances

Continued on other side
Has your child been diagnosed or suspected to have any of the following:

**Asthma?** □ Yes □ No
   - If yes: Has your child been hospitalized? □ Yes □ No
   - Has symptoms with exercise/activity? □ Yes □ No
   - Taken oral steroids? □ Yes □ No
   - If yes, how often? ________________________________

**Eczema?** □ Yes □ No
   - If yes: What skin moisturizers are used? ___________________________________________________
   - How often does your child bathe? ____________________________________________________________
   - Difficulty sleeping due to itching? □ Yes □ No
   - Has your child had skin infections? □ Yes □ No

**Nasal/Eye Allergies?** □ Yes □ No
   - Other symptoms: ____________________________________________________________
   - What triggers your child’s symptoms? ______________________________________________________
   - What seasons are worse? □ Spring □ Summer □ Fall □ Winter □ Always bad

**Increased frequency/severity of infections?** □ Yes □ No
   - If yes: What type of infections? □ Ear infections □ Sinus infections □ Pneumonias □ Bronchitis □ Other
   - How many courses of antibiotics has your child taken in the past 12 months? ____________________

**Food allergies?** □ Yes □ No
   - If yes, please list foods restricted: _________________________________________________________

Has your child had any other medical problems or diagnoses? ________________________________________

Has your child been hospitalized or had any surgeries? If yes, please describe: ________________________

List any medication allergies: _________________________________________________________________

Are your child’s immunizations up to date? □ Yes □ No ; Did your child receive the influenza vaccine this year? □ Yes □ No

**FAMILY HISTORY:** Please indicate if the patient’s parents or siblings have had any of the following conditions:

<table>
<thead>
<tr>
<th></th>
<th>Asthma</th>
<th>Nasal/Eye Allergy</th>
<th>Eczema</th>
<th>Food Allergy</th>
<th>Drug Allergy</th>
<th>Immune Deficiency</th>
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<td>Biological Mother</td>
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<td>Biological Father</td>
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<td>Child’s Brothers and Sisters</td>
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**ENVIRONMENTAL HISTORY:**

Does your child live in: □ An apartment □ A house □ A multifamily house/condo □ Other: ______________

   - Multiple home settings: ________________________________

Do you have a basement? □ Yes □ No ; If yes: Is it □ Finished □ Dry □ Damp □ Has flooded

   - Climate control: □ Hot water heat □ Steam heat □ Forced hot air □ Wood stove □ Space heater
     □ Central AC □ Window A/C □ Air filters □ Air cleaner/ purifier
     □ Humidifier □ Dehumidifier □ Other: ________________________________

Does your home have? □ Mold or mildew □ Damp or musty smell □ Water stains □ Mice □ Cockroaches □ None

   - Flooring: □ Hardwood □ Tile/linoleum □ Wall to wall carpeting □ Area rugs □ Other: ________________________________

Exposure to pets? □ No □ Yes (If yes, please describe): __________________________________________________

Do you or any of your child’s caretakers smoke? □ No □ Yes

Does your child’s bedroom have? □ Stuffed animals □ Rugs □ Carpeting □ Blinds □ Curtains
   □ Air conditioning □ Humidifier □ Feather pillow □ Down comforter
   □ Air cleaner/ purifier □ Allergy-proof mattress or pillow covers

School, work, or day care environment (please describe): ____________________________________________

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**Patient/Patient Representative Signature**

**Date**

**Name (printed):**

**Relationship to patient or Patient**

**Time**

**Date**