Child's Name: ______________________
DOB: ____ / ____ / ____

Children's Hospital Pediatric Center For Atopic Dermatitis and Food Allergy
Parent Report Form

Date:___ /___ /___ Person completing: __________________________ Phone: (____)____-______

Who is your primary care provider? ____
Address: ____
Do you want a letter sent to him/her? ☐ Yes ☐ No

Who referred you to the Pediatric Center for Atopic Dermatitis and Food Allergy?
☐ My child's pediatrician ☐ A friend or relative
☐ Another physician ☐ I referred myself
If other physician: Do you want a letter sent to him/her? ☐ Yes ☐ No
Address: ____

Has your child seen an alternative medicine provider? If so, please indicate treatment (ie. Lactobacillus GG, Acupuncture, etc.). ____

In one sentence, please tell us why you came to the Children's Hospital Pediatric Center for Atopic Dermatitis and Food Allergy: ____
____

How old was your child when the eczema first began? ____ yrs ____ mo.

Is it getting better$_1$, worse$_2$, or not changed$_3$? ________________________________

What time of year is your child's eczema the worst?
☐ Spring$_1$ ☐ Summer$_2$ ☐ Fall$_3$ ☐ Winter$_4$ ☐ Always bad$_5$

What things make your child's eczema worse?
☐ Dogs$_{01}$ ☐ Pollens$_{05}$ ☐ Dust$_{08}$ ☐ Feathers$_{11}$ ☐ Cold air$_{13}$ ☐ Exercise$_{16}$
☐ Cats$_{02}$ ☐ Emotions$_{06}$ ☐ Infections$_{09}$ ☐ Sunscreens$_{12}$ ☐ Medicines$_{14}$ ☐ Foods$_{17}$
☐ Lanolin$_{03}$ ☐ Sweating$_{07}$ ☐ Cigarette smoke/pollution$_{10}$ ☐ Other animals$_{15}$
☐ Strong Odors$_{04}$ (Paint, perfume, cleaning solutions, etc.)

What medicines has your child used for his/her eczema?

Medicine	Medicine Name	Currently using? (Y/N)	How well did it work? Very well	Just Ok	Not at all	Got worse
Steroid cream	____________	_____	☐	☐	☐	☐
Steroid ointments	____________	_____	☐	☐	☐	☐
Oral steroids	____________	_____	☐	☐	☐	☐
Antihistamines	____________	_____	☐	☐	☐	☐
Moisturizers	____________	_____	☐	☐	☐	☐
Epipen Jr/Epipen	____________	_____	☐	☐	☐	☐
Other	____________	_____	☐	☐	☐	☐

Please briefly describe your child's current medical condition. ________________________________
____

What tests has your child had done?

Test	Results
Allergy skin tests	________________________
Skin biopsy	________________________
Patch tests	________________________
Blood tests for allergy (please attach copy)	________________________
Chest or sinus X-rays	________________________
Tests of the immune system	________________________
Other tests	________________________

Was your child breast fed? ☐ Yes$_1$- For how long? ____ mo. ☐ No$_2$

What formula did your child use, if any? ____________________

How old was your child when he/she started solid foods? _____ mo.

Does your child have any other medical problems or chronic conditions? ☐ Yes$_1$ ☐ No$_2$
If Yes, please describe: ____

____

Is your child allergic to any medications? ☐ Yes$_1$ ☐ No$_2$
If Yes, please describe: ____

CHILD HISTORY

Length of pregnancy in weeks _______

Were there any complications during pregnancy (e.g., preterm labor, medical complications, stressors)? ☐ Yes$_1$ ☐ No$_2$
If Yes, please describe: ____

Were there any complications during labor and delivery? ☐ Yes$_1$ ☐ No$_2$
If Yes, please describe: ____

Birth weight ___________

Infancy

	Yes	No		Yes	No
a. Enjoyed Cuddling			Fussy, Irritable		
b. More Active than Other Babies			Sleeping Difficulties		
c. Colic			Feeding Difficulties		

Please record the age at which your child reached the following developmental milestones or check the appropriate box.

	Age	Not Yet	Early	Normal	Late
a. Sat without support					
b. Crawled					
c. Stood without support					
d. Walked without assistance					
e. Spoke first words					
f. Spoke phrases					
g. Spoke sentences					
h. Bowel trained					
i. Bladder trained, day					
j. Bladder trained, night					

Has your child ever had any of the following?

	Yes	No
a. Behavioral Problems		
b. Problems with Attention		
c. Hyperactivity		
d. Problems with Depression		
e. Problems with Anxiety		
f. Obsessive Thoughts/Compulsive Behaviors		
g. Tics and/or Tourette's Syndrome		
h. Learning Problems		
i. Speech/Language Problems		
j.Mental Retardation		
k. Developmental Disorder		

Has your child ever met with any of the following professionals? ☐ Yes$_1$ ☐ No$_2$ If yes, please complete below:

	Currently[✓]	In the past[✓]
Psychologist		
Child Psychiatrist		
Social Worker / Counselor		
Other		

FAMILY HISTORY

Who are the adults in your home?

a. ____________________________ c. ____________________________
b. ____________________________ d. ____________________________

Which of the following best describes the parents’ relationship?

☐ Married ☐ Living together, never married ☐ Not living together, never married
☐ Separated ☐ Divorced ☐ Widowed
☐ Other (please describe): ____

Father’s occupation:________________ DOB:____ / ____ / ____ Highest Grade Completed: _______

Mother’s occupation:________________ DOB:____ / ____ / ____ Highest Grade Completed: _______

Child’s brothers and sisters (and their ages):

a. ____________________________ c. ____________________________
b. ____________________________ d. ____________________________

Has anyone on either side of the family ever had:

☐ Problems with the immune system$_1$ ☐ Cystic Fibrosis$_3$ ☐ Cancer$_5$ ☐ Heart disease$_7$
☐ Diabetes$_2$ ☐ Lung disease$_4$ ☐ Chronic bronchitis$_6$

	Asthma$_1$	Hay fever$_2$	Eczema$_3$	Hives$_4$	Drug Allergy$_5$	Food allergy$_6$	Psoriasis$_7$	Dry Skin$_8$
a. Mother								
b. Father								
c. Brothers & sisters								
d. Mother’s brothers and sisters								
e. Father’s brothers and sisters								
f. Mother’s parents								
g. Father’s parents								

Has anyone (other than the patient) on either side of the family ever had:

	Yes	No	Prefer not to answer
a. Learning/Speech Problems			
b. Behavioral Problems, Hyperactivity			
c. Problems with Attention			
d. Drug or Alcohol Abuse			
e. Problems with Depression			
f. Problems with Anxiety			
g. Tics and/or Tourette’s Syndrome			
h. Mental Health Treatment			

ENVIRONMENT

Do you live in: ☐ An apartment$_1$ ☐ A house$_2$ ☐ A multifamily house/building$_3$

How old is your home? ______________years ☐ Don't Know$_{-8}$

Do you have a basement? ☐ Yes$_1$ ☐ No$_2$

If yes, is it dry$_1$ or damp$_2$? ________

What kind of climate control do you have?
☐ Hot water heat$_{01}$ ☐ Wood stove$_{04}$ ☐ Space heater$_{07}$
☐ Steam heat$_{02}$ ☐ Central or room air conditioning$_{05}$ ☐ Dehumidifier$_{08}$
☐ Forced hot air heat$_{03}$ ☐ Air filters$_{06}$ ☐ Humidifier$_{09}$
☐ Other$_{10}$ ______________

Does your home have: ☐ Mold or mildew$_{11}$ ☐ A damp or musty smell$_{13}$
☐ Mice$_{12}$ ☐ Cockroaches$_{14}$

Do you have:
☐ Hardwood floors$_{15}$ ☐ Tile or linoleum floors$_{17}$ ☐ Area rugs$_{19}$
☐ Wall to wall carpeting$_{16}$ ☐ Under-carpet padding$_{18}$ ☐ Other$_{20}$:______________

Do you own any pets? ☐ Yes$_1$ ☐ No$_2$ If "yes", please describe: _______________________________

Does any one at home smoke? ☐ Yes$_1$ ☐ No$_2$ If "yes", who?_________________________________

Does your child's bedroom have:
☐ Air conditioning$_{01}$ ☐ Rugs or carpeting$_{04}$ ☐ Feather Pillow$_{06}$ ☐ Blinds/Curtains$_{08}$
☐ Humidifier$_{02}$ ☐ An air filter$_{05}$ ☐ Allergy-proof mattress or pillow covers$_{07}$
☐ Stuffed Animals$_{03}$

School or work environment (please describe): ____
____

DAILY TREATMENT ROUTINE

What is your child's daily treatment routine?

Does your child experience treatment/medication side effects? If so, please describe.

Who is primarily responsible for making sure the treatment routine is followed?
___ Parent$_1$ ___Child$_2$ ___Both$_3$ ___ Other$_4$

Who keeps track of medication times? ___ Parent$_1$ ___Child$_2$ ___Both$_3$ ___ Other$_4$
Who keeps track of prescriptions? ___ Parent$_1$ ___Child$_2$ ___Both$_3$ ___ Other$_4$
Who notices symptoms first? ___ Parent$_1$ ___Child$_2$ ___Both$_3$ ___ Other$_4$
Who follows dietary restrictions? ___ Parent$_1$ ___Child$_2$ ___Both$_3$ ___ Other$_4$
Who makes sure triggers are avoided? ___ Parent$_1$ ___Child$_2$ ___Both$_3$ ___ Other$_4$

What is the most difficult part of the condition?

What is the most difficulty part of the treatment regimen?

What does your child know about his/her medical condition?

What seems to help your child manage his/her medical care?

What seems to make it harder for your child to manage his/her medical care?

Are there others (friends, family) who are involved in your child's daily medical care? ☐ Yes$_1$ ☐ No$_2$
If Yes, Who?

If you were suddenly unavailable, how many people would be able to manage your child's daily treatment regimen? ___ people available ☐ No one available$_{-8}$

What role does the school /school nurse / daycare provider play in your child's daily medical care?

DAYCARE

Does your child attend daycare? ☐ Yes$_1$ ☐ No$_2$

If Yes, How many days per week? _____ days
What type of setting (e.g., home, center, etc.) ____
Do you feel your child's daycare meets your child's needs? ☐ Yes$_1$ ☐ No$_2$
Please describe:

SCHOOL

Child's grade in school (if applicable) ______
Has your child ever been retained in a grade? ☐ Yes$_1$ ☐ No$_2$
Does your child receive any special services through the school (IEP, tutor)? ☐ Yes$_1$ ☐ No$_2$
If yes, please describe:

Approximately how many full days of school per week has your child missed in the past 6 months? ___
Approximately how many partial school days have been missed? __
Approximately how many days of PE/physical activity per week have been restricted? ___
Does your child's medical situation interfere with participation in school activities? ☐ Yes$_1$ ☐ No$_2$
If yes, please describe:

Does your child's medical situation affect his/her learning or attention/concentration? ☐ Yes$_1$ ☐ No$_2$
If yes, please describe:

Do you feel your child's school meets your child's needs? ☐ Yes$_1$ ☐ No$_2$
Please describe:

ACTIVITIES

What does your child enjoy doing in his/her time outside of school?

Approximately how many days of social activity per week are restricted because of his/her condition or treatment? ______

Are there activities or people your child avoids because of his/her appearance? ☐ Yes$_1$ ☐ No$_2$
If yes, please describe.

SLEEP

1=Rarely/Never; 2=Occasionally; 3=Sometimes; 4=Often; 5=Most of the time

How often does your child:

a. Have difficulty falling asleep at night?	1	2	3	4	5
b. Wake during the night because of itching?	1	2	3	4	5
c. Scratch his/her skin while asleep?	1	2	3	4	5
d. Have difficulty waking up in the morning?	1	2	3	4	5
e. Seem tired during the day?	1	2	3	4	5
f. Seem irritable during the day?	1	2	3	4	5
g. Complain about his/her sleep?	1	2	3	4	5

MOOD

1=Rarely/Never; 2=Occasionally; 3=Sometimes; 4=Often; 5=Most of the time

How often does your child's illness affect his/her mood? 1 2 3 4 5

Please describe:

To Be Completed by Office:
Patient ID # ____ ____ ____-____ Date of Visit: __ __/__ __/__ __ __ __
Person Entering: _______ Date Form Entered __ __/__ __/__ __ __ __