BRIGHAM HEALTH
BRIGHAM AND WOMEN'S HOSPITAL

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Allergy and Clinical Immunology
Brigham and Women's Hospital

Brigham and Women's Hospital Pediatric Allergy/Immunology Patient Questionnaire

Patient Name _____ Patient Date of Birth _____

Person completing _____ Relationship to patient _____

Date _____

Address _____

Home telephone _____ Cell number _____

Emergency contact (if different from above) _____

Who is the child's pediatrician? _____

Address of pediatrician _____

Referring physician (if not pediatrician) _____

Address of referring physician _____

What other health care professionals have evaluated the child? _____

Please list the main reasons for the child's visit today

_____

_____

Does the child have any of the following symptoms (please circle):

sneezing	blocked nose or congestion	watery nose	shortness of breath
wheezing	chest tightness	cough	sputum (phlegm)
coughing at night	severe itching	severe swelling	acid stomach/ abdominal pain
difficulty breathing	frequent vomiting	frequent diarrhea	frequent fevers

Has the child been told, or do you suspect he/she has any of the following (please circle):

sinusitis	asthma	nasal polyps	recurrent bronchitis
bronchiolitis	eczema	hives	stomach reflux
pneumonia	allergic rhinitis or hayfever	frequent infections	ear infections (how many per year?_____)
croup	enlarged adenoids/ tonsils		

What times of year is the child's problem the worst?

☐ spring ☐ summer ☐ fall ☐ winter ☐ always bad

What things make the child's problem worse?

☐ dogs ☐ feathers ☐ cold air ☐ infections/ "colds"

☐ cats ☐ dust ☐ exercise ☐ cigarette smoke/pollution

☐ other animals ☐ pollen ☐ emotions ☐ other _____

☐ strong odors (paint, perfume, etc.) ☐ change of seasons or weather

How many school days did the child miss in the last year because of his/her illness?

How many times in a month does the child awaken at night because of his/her illness?

Is the child's exercise or activity limited by his/her illness?

Birth History

Was the child born full-term? _____ Did the child have breathing problems at birth? _____

Was the child fed: ☐ breast milk ☐ milk-based formula ☐ soy formula ☐ other formula

Has the child received all standard vaccinations for his/her age group? _____

What medicines have been used for your child's problem?

Name of medicine	Is he/she using it now? (yes/no)	How well did it work? very well	okay	not at all
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

What tests have been done for the child?

Test	Results
Allergy skin prick tests	_____
Allergy blood tests (RAST)	_____
Sweat test for cystic fibrosis	_____
Chest or sinus X-Ray	_____
Tests of the immune system	_____
Breathing tests	_____
Other tests	_____

Does the child have any other medical problems? Please describe

_____

Is the child allergic to any medications? Please describe

_____

Has the child had any adverse food reactions? Please describe

_____

Is the child allergic to any insects? Please describe

Family History

Father's occupation_____ Mother's occupation_____

	asthma	hay fever	eczema	hives	immune deficiency	food allergy
mother						
father						
patient's siblings						

Environment

What type of home does the child live in? house apartment multifamily

Location of home: city suburb rural

Does the home have a basement? _____ If so, is it damp or dry?_____

What kind of climate control and heating does the home have?

☐ forced hot water ☐ forced hot air ☐ humidifier ☐ dehumidifier

☐ wood stove ☐ space heater ☐ air filter ☐ central air conditioning

☐ room air conditioning

What type of flooring does the bedroom have?

☐ hardwood floors ☐ wall-to-wall carpeting ☐ area rugs ☐ tile/linoleum

Does the home have any pets? Please list

Does anyone smoke at home? If so, who

How many courses of oral steroids (prednisone/prednisolone) did the child need in the last year? _____

How many times has the child had to go to the emergency room for an asthma attack? _____

Has the child ever been intubated or been in the Intensive Care Unit due to an asthma attack?_____

Has the child ever had a severe allergic reaction (anaphylaxis)?_____

Have you (or the child for whom you are filling out this form) ever felt unsafe or been afraid in the home?

Does the child experience pain as part of his/her daily life?

If yes, describe the location(s), onset, duration, and characteristics of the pain

Reviewed by: M.D.

Review of Patient Systems Please answer N/A (Not Applicable) if the question does not apply to the child's age-group.

	Yes	No	N/A		Yes	No	N/A
General:				**Genitourinary:**			
Recurrent fevers				Blood in urine			
Large weight gain/loss				Pain or burning with urination			
Difficulty sleeping				Problems with menstruation			
Eyes:				Other:			
Blurred vision				**Neck:**			
Pain in eyes				Swelling			
Other:				Lumps			
Ear/Nose/Throat:				**Skin:**			
Nose bleeds				Rashes			
Hearing difficulty				Bruises easily			
Sinus trouble				Dry skin			
Ear pain/popping				Other:			
Mouth/tooth/tongue problems				**Endocrine:**			
Persistent hoarseness				Constant thirst			
Other:				Too warm/too cold			
Cardiovascular:				Jumpy/nervous			
Fluttering heart				Other:			
Unusual heartbeat				**Bones/Joints:**			
Chest pain				Painful joints			
Other:				Swollen joints			
Respiratory:				Muscle pain/tenderness			
Shortness of breath				Other:			
Poor exercise tolerance				**Neuromuscular:**			
Persistent cough				Weakness in arm/leg			
Wheezing				Difficulty with balance			
Other:				Dizzy, fainting spells			
Gastrointestinal:				History of seizures			
Abdominal pain				**Psychological:**			
Diarrhea				Feelings of depression			
Constipation				Hyperactivity			
Frequent spit-up				Attention difficulties			
Frequent vomiting				Anxiety			
Other:							
				Has the child ever:			
				Considered suicide			
				Attempted suicide			

Patient or Guardian Signature: Reviewed by: M.D.

Date: