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ASTHMA AND ALLERGY CONSOLATION(PEDIATRICS)

Name: ______________________________ Date: ____________

Age: __________ Date of Birth: ________________ Referred by: ______________

Current Physician/Pediatrician: ______________________________

What health problems is your child having? What would you like to learn and what changes would you like to see for your child as a result of this consultation?

Current Medication			Drug Allergies	Reaction
Drug	Dose	How Often		
			Food Allergy	Reaction

Over the Counter medication, nose sprays or vitamins, not mentioned above?
____

Diet: regular: ____________ Special Diet: ____________________

BIRTH HISTORY: Birth Weight: ______ Lbs.________ oz. Length: _________
Complication of Pregnancy: ____
Full term: ____ Yes _____ No Neonatal Complications: _______________

FAMILY HISTORY: (Note: Allergy & Asthma Problems)

Mother's Age: _____ Smoker ____Yes ____No / Health Status: __________

Father's Age: ______ Smoker_____ Yes ____No / Health Status: _________

Legal Guardian Name & Age(if not the parent) _____________ Smoker__ Yes ___ No
Parental Marital Status(Please Circle) Married-Divorced-Separated-Not married-Living together

Child's Siblings	Age	Health Status

Any on-going or significant past illness? _______________________________

Past Surgeries	Year	Hospitalizations	Year

ER? Urgent Care Visits for what and when?
____

Pets: ☐ Dog(s) ☐ Cat(s) ☐ Reptile(s) ☐ Fish ☐ Rodents ☐ Bird(s) ☐ Others

YOUR CHILD'S NOSE (check all that pertain)
☐ Seasonal symptoms ☐ Symptoms worse in the morning? ☐ Snores
☐ Year-round symptoms ☐ Mouth breather ☐ Frequently sneezes
☐ Nasal polyps ☐ Symptoms with pet exposure ☐ Other

YOUR CHILD'S EARS: ☐ Frequent ear infections ☐ Tubes

YOUR CHILD'S SKIN: ☐ Dry Skin ☐ Hives ☐ Eczema ☐ Other___________

CHILD HAS HISTORY of: Sinus infections Reflux Pneumonia Croup RSV

Age of onset of allergy, wheezing, or chronic cough? ____________________
Number of school days misses in the past twelve months. _________________
Number of Emergency visits for asthma or respiratory distress in the past? _________
Number of episodes of asthma (any asthma problems which cause you to modify you child's activity or take different medications)
_____times per year _____times per month _____per week ____time per Season

ASTHMA or ALLERGY TRIGGERS: Activities or substance that bring on symptoms
☐ Respiratory infections ☐ Cats ☐ Morning cough ☐ Pollen ☐ Molds ☐ Cold air
☐ Pollutants ☐ Dogs ☐ Nighttime cough ☐ Perfumes ☐ Smoke ☐ Exercise
☐ Other____

Do Symptoms get worse at certain time of year?

☐ Spring ☐ Summer ☐ Fall ☐ Winter

Does the child vomit, followed by cough, or have wheezy cough at night? Y / N

Are his/her symptoms worse after feeding? Y / N

ASTHMA HISTORY

DOES YOU child HAVE: In the past month(circle that applies

Wheezing	No	<2 times a week	>2 times a week	Daily
Coughing	No	<2 times a week	>2 times a week	Daily
Shortness of breath	No	<2 times a week	>2 times a week	Daily
Rapid Breathing	No	<2 times a week	>2 times a week	Daily
Chest tightness	No	<2 times a week	>2 times a week	Daily
Chest Pian	No	<2 times a week	>2 times a week	Daily
Throat clearing	No	<2 times a week	>2 times a week	Daily
Difficulty breathing in	No	<2 times a week	>2 times a week	Daily
Coughing at night	No	<2 times a week	>2 times a week	Daily
Rescue medication	No	<2 times a week	>2 times a week	Daily

Steroid use: ☐ No ☐ This week ☐ This month ☐ Last month ☐ This year ☐ Last year

Do you use an Aerochamber for the child's medicine? ☐ Yes ☐ No

Do you use a tight fitting mask for you child's nebulizer? ☐ Yes ☐ No

Living Environment: ☐ House(age of house___) ☐ Apartment ☐ Trailor ☐ City ☐ Rural

Type of Heat: ☐ Gas forced air ☐ Electric ☐ Wood burning ☐ Steam ☐ Oil ☐ Humidifier Central/Room

Air Conditioning: ☐ None ☐ Central ☐ Room ☐ Dehumidifier

Bedroom: Bed ☐ Conventional Mattress ☐ Waterbed ☐ ____________

Pillow ☐ Polyester fill pillow ☐ Foam ☐ Down

Flooring: ☐ Carpet ☐ Hardwood ☐ Linoleum ☐ Vinyl

Basement: ☐ None ☐ Partial ☐ Full ☐ Damp

Is there anything else you would like us to know?

Controlling you child's asthma or allergy symptoms is a PARTNERSHIP between YOU and ALLERGY ASTHMA CARE.

A child MUST be ASSISTED or SUPERVISED by an adult When taking a prescribed medication.