St. Paul Allergy & Asthma

CHILD'S NAME: ______________________________________ **TODAY'S DATE:** ___________________________

DATE OF BIRTH: ______________________________________

PARENTS' NAMES/CONTACT #S: _________________________________ _________________________________

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Primary Care Provider (Name/Clinic): ______________________________________

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Can we send a letter back to your child's primary provider? ☐ **YES** ☐ **NO**

What are your primary goals for this visit/questions you have for your child's doctor?

☐ ____

☐ ____

☐ ____

☐ ____

PLEASE CHECK THE SYMPTOMS YOUR CHILD IS CURRENTLY/VERY RECENTLY EXPERIENCING:

GENERAL:

☐ Fever

EYES:

☐ Itchy
☐ Watery
☐ Red
☐ Puffy

EARS/NOSE/SINUSES/THROAT:

☐ Stuffy nose ☐ Snoring
☐ Runny nose
☐ Sneezing
☐ Itchy nose

LUNGS:

☐ Cough
☐ Shortness of breath
☐ Wheezing
☐ Swelling

GI TRACT:

☐ Difficulty Swallowing
☐ Weight loss

SKIN:

☐ Eczema
☐ Hives
☐ Itching

LOCAL PHARMACY:

Name: ____
City: ____
Cross-streets: ____________________________________

MAIL-ORDER PHARMACY:

Name: ____

Do you have forms that you need completed by your child's doctor? ☐ YES ☐ NO