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

PREFERRED NAME/PRONOUNS: ________________________

DATE OF BIRTH: ______________________________________

PARENTS' NAMES/CONTACT #S: _________________________________ _________________________________

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Primary Care Provider (Name/Clinic): ______________________________________

____

Referred by (Name/Clinic): ______________________________________

____

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

How did you hear about our practice?

☐ Doctor/healthcare provider ☐ Recommended by family member/friend ☐ Insurance search
☐ Google/online search ☐ Advertisement _________________________ ☐ Drive-by sighting
☐ Other __________________________

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
☐ Runny nose
☐ Sneezing
☐ Itchy nose
☐ Nosebleeds
☐ Snoring

LUNGS:
☐ Cough
☐ Shortness of breath
☐ Wheezing

HEART/BLOOD VESSELS:
☐ Color changes of skin
☐ Irregular heartbeat
☐ Swelling in hands/feet

GI TRACT:
☐ Stomach pain
☐ Diarrhea
☐ Difficulty swallowing
☐ Weight loss

SKIN:
☐ Eczema
☐ Hives
☐ Itching
☐ Swelling

MUSCLES/BONES:
☐ Joint pain
☐ Joint redness
☐ Joint swelling

BLOOD:
☐ Swollen glands/nodes

NERVOUS SYSTEM:
☐ Pain

LOCAL PHARMACY:
Name: ____
City: ____
Cross-streets: ______________________________________

MAIL-ORDER PHARMACY:
Name: ____

St. Paul Allergy & Asthma

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PAST MEDICAL HISTORY:

Check all that apply:

☐ Seasonal allergies
- ☐ Spring
- ☐ Summer
- ☐ Fall
- ☐ Winter
- ☐ All year symptoms

☐ Pet allergies
- ☐ Dogs
- ☐ Cats
- ☐ Rabbits
- ☐ Other _____________
- ☐ Other_____________

☐ Asthma/coughing/wheezing
- ☐ With illness
- ☐ With exercise
- ☐ With allergy symptoms
- ☐ With cold/humid air
- ☐ Around smoke/irritants

☐ Hives
- ☐ With heat exposure
- ☐ With cold exposure
- ☐ With pressure
- ☐ With friction/vibration
- ☐ Due to medications ______________________
- ☐ Due to foods ___________________________

☐ Eczema
- ☐ In the winter/cold exposure
- ☐ In the summer/heat exposure
- ☐ With exposure to chlorine
- ☐ Due to foods ____________________________
- ☐ Due to environmental allergies_____________

____

☐ Food allergies -> list culprit foods: ____

____

☐ Recurrent infections -> list:

____

Other conditions:

☐ Heartburn/reflux ☐ Heart disease ☐ Thyroid disease ☐ Latex allergy

☐ __________________ ☐ _________________

Was your child previously been tested for allergies? ☐ YES; when/where________________________________ ☐ NO

Did your child previously take allergy shots? ☐ YES; how long/helpful? __________________________________ ☐ NO

Does your child have a penicillin allergy? ☐ YES; did they have testing_____________________________ ☐ NO

Prior severe reaction to a bee/wasp/hornet sting? ☐ YES - have they had testing______________________ ☐ NO

PAST SURGICAL HISTORY:

☐ Tonsillectomy (year_____) ☐ ______________________ (year_____)

☐ Adenoidectomy (year_____) ☐ ______________________ (year_____)

☐ Sinus surgery (year_____) ☐ ______________________ (year_____)

☐ Ear tubes (year_____) ☐ ______________________ (year_____)

PRIOR HOSPITALIZATIONS:

☐ ______________________ (year_____) ☐ ______________________ (year_____)

☐ ______________________ (year_____) ☐ ______________________ (year_____)

==

MEDICATIONS:

☐ ______________________________ ☐ ______________________________ ☐ ______________________________
☐ ______________________________ ☐ ______________________________ ☐ ______________________________
☐ ______________________________ ☐ ______________________________ ☐ ______________________________
☐ ______________________________ ☐ ______________________________ ☐ ______________________________

MEDICATION ALLERGIES:

☐ ____________________ (reaction___________________) ☐ ____________________ (reaction___________________)
☐ ____________________ (reaction___________________) ☐ ____________________ (reaction___________________)
☐ ____________________ (reaction___________________) ☐ ____________________ (reaction___________________)

FAMILY MEDICAL HISTORY:

☐ Environmental allergies ☐ Asthma ☐ Eczema ☐ COPD
☐ Immune deficiency/severe infections ☐ _____________________________ ☐ ___________________________

SOCIAL HISTORY:

☐ No pet exposures ☐ Current pet exposures (type, location) ____
☐ Exposed to tobacco/vaping 2nd hand
☐ Travel outside the US in the past 6 months (list countries) ____
☐ Primary language __________________ ☐ Race/ethnicity __________________ ☐ Country of origin____________________

WORKPLACE HISTORY:

Is your child currently in school? ☐ YES ☐ NO

- If yes, what grade/school? ____
  Are their symptoms worse at school? ____

ENVIRONMENTAL HISTORY:

Describe your home: ☐ House ☐ Condo ☐ Townhome ☐ Apartment ☐ Other
☐ City ☐ Suburbs ☐ Rural area/farmstead ☐ Other

What year was your home built? ______________

Describe your HVAC: ☐ Forced air heat ☐ Gas heat ☐ Electric heat ☐ Hot water heat
☐ Wood-burning stove ☐ Kerosene heat ☐ Space heater ☐ Other____________________
☐ Central A/C ☐ Window A/C unit(s) ☐ Other____________________
☐ No mold/water damage in home ☐ Damp basement at times ☐ Current mold/water - needs remediation