Banner Health®

NEW PATIENT MEDICAL HISTORY
CHILD / ADOLESCENT ALLERGY

Patient Name: _____ **Date of Birth:** _____

Please provide as much detail as you are able so that we can give you the safest and best care possible.

Preferred Pharmacy (name and location): _____

Primary Care Provider

Name: _____ Phone #: _____

Address: _____ Fax #: _____

Reason for visit (Check all that apply)

❑ **Nasal or Sinus Problems** ❑ **Skin Rash/Hives** ❑ **Chest Problems** ❑ **Food Allergies** ❑ **Frequent Infections**

___ Sneezing
___ Itching of:
  ___ Eyes
  ___ Ears
  ___ Nose
  ___ Palate (Roof of Mouth)
___ Clear Watery Nose
___ Puffy or Swollen Eyes
___ Watery Eyes
___ Stuffy Nose
___ Post Nasal Drainage/Throat Clearing
___ Frequent Raw Throat
___ Nasal Polyps
___ Frequent Headaches
___ Frequent Ear Infections
___ Sinusitis
___ Broken Nose
___ Mouth Breathing/Bad Breath
___ Trouble Breathing (Nasal/Sinus OR Chest)
___ Awaken at Night with Chest Symptoms
___ Wheezing When Breathing
___ Tightness in Chest
___ Frequent Cough
___ Wheezing with Exercise
___ Asthma
___ Pneumonia
___ Bronchitis

Other: _____

When did your symptoms begin? _____

When did you last have symptoms? _____

Have your symptoms ever limited your activity at school or work? ❑ Yes ❑ No If yes, explain: _____

_____

Have you lost time form school or work? ❑ Yes ❑ No If yes, explain: _____

_____

ALLERGIES

❑ **No Known Allergies** List any allergies and intolerances to **medications, food or the environment.**

Allergy	**Reaction**

Stinging Insect Allergy: ❑ Bee ❑ Wasp ❑ Yellow Jacket ❑ Fire Ant

Reaction: _____

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MEDICATIONS

❑ **Not taking any medications**

List any medications, vitamins, supplements, and over the counter medications you are taking, with dose and how often.

Medication Name	Dose	How often?

MEDICAL HISTORY

What **medical** problems have you had? Please mark **all** that apply:

	CONDITION:	ONSET DATE:		CONDITION:	ONSET DATE:		CONDITION:	ONSET DATE:
	Acute ear infections			Diabetes			Pleurisy	
	Allergic rhinitis			Eczema			Pneumonia	
	Asthma			Environmental allergies			Recurrent pneumonia	
	Atopic dermatitis			Hives			Sinusitis	
	Bronchitis			Immune disorder			Sleep apnea	
	Chronic cough			Immunodeficiency			Thyroid disease	
	Chronic ear infections			Nasal fracture			Tonsillitis	
	Contact dermatitis			Nasal polyps			Other:	
	Deviated nasal septum			Pet allergies				

Other medical problems:

_____

_____

Recent hospitalizations or ER visits (provide dates and reason below)?

Date	Reason	Date	Reason

SURGICAL HISTORY

Has your child had any of the following surgeries? ❑ No prior surgeries.

❑ Adenoidectomy Date: _____ ❑ Nasal surgery Date: _____

❑ Ear tube placement Date: _____ ❑ Tonsillectomy Date: _____

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FAMILY HISTORY

*Conditions Related to Allergy, Asthma & Immunology Only

Mother:	❑ Allergies/Hay Fever	❑ Asthma	❑ Hives	❑ Sinusitis	❑ Eczema
Father:	❑ Allergies/Hay Fever	❑ Asthma	❑ Hives	❑ Sinusitis	❑ Eczema
Sister(s):	❑ Allergies/Hay Fever	❑ Asthma	❑ Hives	❑ Sinusitis	❑ Eczema
Brother(s):	❑ Allergies/Hay Fever	❑ Asthma	❑ Hives	❑ Sinusitis	❑ Eczema
Other family Members:	❑ Allergies/Hay Fever	❑ Asthma	❑ Hives	❑ Sinusitis	❑ Eczema

Any Additional Pertinent Family History: _____

_____

SOCIAL HISTORY

TOBACCO / ALCOHOL / CAFFEINE / DRUGS

(For patients 12 and older)

Tobacco/smoking status: Never _____
Current _____ Type _____ Amount _____ Duration _____
Former _____ Type _____ Amount _____ Duration _____

Tobacco use in the household? ❑ Yes ❑ No

Do you use alcohol? ❑ Yes ❑ No Type _____ Amount _____ Frequency _____

Alcohol use in the household? ❑ Yes ❑ No

Do you use recreational drugs? ❑ Yes ❑ No Type _____ Amount _____ Frequency _____

Substance abuse use in the household? ❑ Yes ❑ No

TOBACCO / ALCOHOL / CAFFEINE / DRUGS

(For patients under 12)

Tobacco use in the household? ❑ Yes ❑ No

Alcohol use in the household? ❑ Yes ❑ No

Substance abuse use in the household? ❑ Yes ❑ No

HOME ENVIRONMENT

Child lives with: _____

EXERCISE

Do you exercise? ❑ Yes ❑ No If yes, list type of exercise and number of times/week: _____

EMPLOYMENT/SCHOOL

Grade in school: _____ Name of school: _____

Occupation _____ Employer _____

OTHER

Do you have animals in the home? ❑ Yes ❑ No If yes, type: _____

IMMUNIZATIONS

❑ Immunization History Unknown ❑ Immunizations up-to-date ❑ No immunizations by choice
❑ Missing some immunizations

Date of last influenza vaccine: _____

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ALLERGY, ASTHMA & IMMUNOLOGY PERTINENT HISTORY

List other geographic areas you have lived in: _____ _____ _____

How long have you lived in Colorado: _____

Home Environment: ❑ House ❑ Duplex ❑ Condo ❑ Department ❑ Modular home **Years lived there:* _____

❑ Air conditioning ❑ Carpeting ❑ Down bedding ❑ Dusty hobbies _____ ❑ Forced air heat

❑ Previous flooding (Year: _____)

Have you ever been skin tested before? ❑ Yes ❑ No If yes, date: _____

Technique used: ❑ Pricked/scratched on the skin ❑ Injections into the skin

Have you ever been on allergy shots? ❑ Yes ❑ No If yes, date: _____

What medications have you found helpful for: (Specify name if known)

Nasal Problems:

❑ Antihistamines ❑ Nose drops ❑ Nasal steroid sprays ❑ Over the counter antihistamines ❑ Eye drops

Eye Problems:

❑ Antihistamines ❑ Over the counter antihistamines ❑ Eye drops

Chest Problems:

❑ Asthma inhalers ❑ Antihistamines ❑ Anti-Leukotrienes (Singulair, Accolate, Zyflo)

Skin Problems:

❑ Steroid creams ❑ Non-steroidal creams ❑ Over the counter creams ❑ Antihistamines

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