BRANFORD PEDIATRICS & ALLERGY, P.C.

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Date:___________

PLEASE FILL OUT FOLLOWING ALLERGY HISTORY AS THOROUGHLY AS POSSIBLE: History given by:________________________

PATIENT'S NAME:____ DATE OF BIRTH:__________________
CURRENT WEIGHT:________

PRIOR ALLERGY EVALUATION?____
MEDICATION ALLERGIES?_____________________WHEN?______________WHAT HAPPENED?____________________

WHO REFERRED YOU?________________________CURRENT PEDIATRICIAN:________________________

MAJOR CONCERN:____

What goal would you like to achieve in managing your child's allergies/asthma/food allergy?______________________

HISTORY OF:	Yes	No
Nasal Congestion	___	___
Nasal Discharge	___	___
Nasal Itching	___	___
Sneezing	___	___
Post Nasal Drip	___	___
Throat Clearing	___	___
Eye Itching	___	___
Eye Tearing	___	___
Frequent headaches	___	___
Wheezing ever heard?	___	___
Cough with activity?	___	___
Wheezing with Colds?	___	___
Shortness of Breath	___	___
Day cough	___	___
Night cough	___	___
Fatigue with activity	___	___
Heartburn/Reflux	___	___
Frequent Abdominal Pain	___	___
Special Formulas Needed	___	___
Eczema Patching	___	___
Constant Itch	___	___
Hives	___	___
Throat Itching	___	___
Mouth Itching	___	___
Food Reaction	___	___

	Yes	No	
Frequent Ear Infections	___	___	
Frequent Sinus Infections	___	___	
Sinus CT Scan	___	___	
Chest X-ray	___	___	
Pneumonia	___	___	When? ____________________
Bee Sting Allergy	___	___	
Ever Seen a:			
Ear Nose & Throat Doctor	___	___	
Eye Doctor	___	___	
Skin Doctor	___	___	
Stomach Doctor	___	___	
Lung Doctor	___	___	
Heart Doctor	___	___	
Naturopath	___	___	
Chiropractor	___	___	
Homeopath	___	___	
Tonsils Removed?	___	___	
Adenoids Removed?	___	___	
PE Tubes in Ears?	___	___	
Taken Oral Steroids?	___	___	

Food Reaction Details:____
____
____

Wheezing/Coughing Triggers: Which seasons?____________________Colds?___Exercise?___Smoke?___Cold Air?___Cat?___Dog?___
Ever Been Hospitalized?_______________________________________ER for wheezing?__________________________

Family history of Allergy/Asthma/Eczema? (who? what?):____

Please list all medications tried for allergies/asthma: (including prescription, over-the-counter, naturopathic or homeopathic medications)

Date	Medication	Dose	Effective?

Home Environment: Age of Home_____ Type of Home___________________________ Carpeting in Bedroom? _____ Central Air? ____
Type of Heat? ______________Woodstove? ______ Pet in Home?____
Share Households?____
Smoker in Child's Life?____