For office use only:
Height: _____ Inches
Weight: _____ lbs
Blood pressure:

AHN PEDIATRICS
Pediatric Alliance

Adult and Pediatric Allergy, Asthma, & Immunology

Patient Name_____ DOB: _____Date_____

Name AND location of your preferred pharmacy? _____

IF you use a mail order pharmacy, which one do you use? _____

Were you referred by a health care provider? ___yes ____no If yes, who_____

Reason for visit (Select all that apply)

___Nasal and/or eye allergy
___Asthma
___Cough
___Food allergy
___Drug allergy
___Bee sting allergy
___Recurrent infections ___ear ___sinus ___pneumonia
___Hives
___Eczema
___Other_____

Patient History: Check if the patient has ever been diagnosed with the following
___Food Allergy If yes, specify food and reaction type _____
___Medication allergy If yes, specify medication and reaction type _____
___Bee sting allergy If yes, specify reaction type _____
___Environmental allergy
___Asthma
___Bronchitis ___Pneumonia
___Eczema ___Ear infections
___GERD (chronic heartburn) ___Recurrent sinus infections
___Vocal cord dysfunction ___Hives
___Headaches ___Chronic cough

Is the patient adopted? __Yes ___No If no, complete the following section on family history

Family History: Please check if a family member has ever been diagnosed with the following:

	Mother	Father	Sister	Brother	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather
Environmental Allergies								
Drug Allergies								
Asthma								
Eczema								
Thyroid Disease								
Recurrent Sinus Infections								

Recurrent Ear infections								
Pneumonia								
Urticaria/Hives								
Celiac Disease								
GERD								
Immune Deficiency								

Social and Environmental History:

1. Are you a current smoker? _____ Are you a former smoker? _____
2. What type of exercise do you enjoy? (Jogging, baseball, swimming, etc)
   _____ How many times per week? _____
   _____ How many times per week? _____
   _____ How many times per week? _____

3. What year was your home built? _____
4. Are there any smokers in your home? Yes_____ No_____
   If so, what is the relationship to the patient? (Mother, brother, etc) _____
5. Does your home have central air conditioning? Yes_____ No_____
6. How old is your mattress? _____
7. Do you use allergy encasings on pillow and/or mattress? Yes_____ No_____
8. What type of flooring do you have in most of your rooms?
   Carpeting_____ Hard wood_____ Area rugs_____ Tile_____
9. If you have pets…what type and how many (dogs, cats, gerbils, etc)
   _____ _____
   _____ _____
   _____ _____

Please list **ALL** prescription and over the counter medications

MEDICATION DOSE HOW OFTEN

_____

_____

_____

_____

_____

Signature of person completing form_____