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MINOR/CHILD REGISTRATION

Name: _____ Age: _____ Date of Visit: _____

Date of Birth: _____ Sex: Male/Female

Completed by: _____ Relation: _____

Phone: Home: _____ Cell: _____ Work: _____

Email: _____

Please write yes (Y) or no (N), circle or explain where required, N/A-Not Applicable

Whom may me thank for referring you? _____

Primary Care Doctor: Dr. _____ **Other MD's treating you?** _____

List current medications taken on a regular basis: _____

_____

Any known **Drug (Medication) Allergies?**
If yes, list: _____
What type of reaction occurs? _____

Any known **Food Allergies?**
If yes, list and briefly describe reaction: _____

Please answer ALL questions:

What is your primary reason or chief complaint for seeing allergy doctor today? (Describe in detail).

Allergies Sinus problems Asthma Eczema Hives Rash Itching

Allergic Reaction Food allergies Insect Stings Drug Allergies Latex Allergy others

_____

_____

_____

_____

CIRCLE MAJOR SYMPTOMS (Problems) – those that prompted your visit here:

NOSE:	Runny nose-Watery	Stuffy nose/Blocked nose	Itching/Rubbing the nose	
	Sneezing	Nosebleeds	Snoring or Mouth breathing	Loss of smell
EYES:	Dark Circles	Itching/ Burning	Redness/ Tearing	Swelling
EARS:	Itching	Popping/ Fullness of ears	Blocking	Infections
	Hearing Loss	Dizziness	Drainage from outer ear	Any Ear tubes?

THROAT:	Itching	Drainage/Post nasal drip	Constant clearing of the throat			Sore throat
	Mucus in the morning		Voice loss	Hoarseness		Sinus infections
CHEST:	Cough	Wheezing	Chest tightness	Shortness of breath		
	Cough or Shortness of breath on exercise/ sports			Chest Infections		Bronchitis
	Inability to get a good breath or let all air out of lungs					
HEADACHE:	Over eyes	Over cheeks/mid face	Back of neck	Sinus headache	Migraine	
	Tension	Associated triggers and symptoms:				
SKIN:	Rash	Hives/welts	Itching	Dryness	Eczema	Other
INSECT STING REACTIONS Or Allergic Reactions:	Hives		Swelling		Shortness of breath	
	Itching	Dizziness	Fainting			
STOMACH:	Nausea	Vomiting	Cramps	Bloating	Indigestion	
	Diarrhea	GE Reflux	Suspect Responsible foods:			
OTHERS:						

How long has your child had these symptoms? _____

Which of the allergy symptoms bothers your child the most? _____

Are the symptoms around the year (perennial)? _____

Are there any particular seasons/ months that the symptoms are worse? _____

Circle any of the following that causes or makes your symptoms worse: (TRIGGERS)

Allergens	Irritants	Ingestants	Weather
House dust	Perfumes/Cosmetics	Alcoholic Beverages	Weather change
Fresh cut grass	Soaps/Detergents	Drugs	Cold fronts
(Lawn mowing)	Insecticide	Foods, hot spicy	Heat/Hot weather
Dead grass	Cleaning agents	Other foods/Fruits	Windy days
Old leaves	Strong odors	Others :(List)_____	Damp/Rain
Hay	Paint	_____	Muggy weather
Cats	Hair spray	_____	
Dogs	Air conditioners	_____	
Feathers	Exhaust fumes		

Misc: Exertion; Cold symptoms/URI; Cigarette smoke/Tobacco
Excitement; Stress/Worry; Laughing
Staying lakeside/barns/summer homes/dry attic; Emotional upset/Depression

What treatment have you tried or been given for this illness? _____
Antihistamines/ Decongestants/ Nose sprays/ Eye drops/Allergy shots
What helped most? _____
List any medication taken on a regular basis for relief of allergy symptoms: _____

Under what circumstances are your child allergy symptoms relieved (relieving factors)? _____

Has your child had any allergy testing or allergy shots before? Yes No If yes, provide details: _____

_____

Circle the time symptoms are worst: Early morning Afternoon Evening Nighttime

Where were the symptoms worst: Home Outdoors At work Vacation
Staying nearby Elsewhere

Which type of weather makes symptoms worse? Windy Cold Hot Wet Dry

Effect of vacation/travel or major geographical change? _____

Past Allergic/Immunological Disease history?

Asthma Hay Fever Hives Rash Eczema RSV bronchiolitis
Insect Stings Mosquito bites Poison Ivy Latex allergy
Recurrent Infections of: Ears Throat Sinus Infections Pneumonia Skin
Bone Others:
Congenital immune deficiency diseases: HIV/AIDS Oral Thrush/ Yeast Infections
Meningitis/Septicemia/Bacteremia / Bone infections/Systemic invasive infections

Past Medical history:
General Health: Good/Otherwise
Gaining weight and eating well:
Any medical problem?
Any major illnesses?
Any Hospitalizations:
When? _____ Where? _____
Why? _____
Any surgeries? Ear tubes _____
Tonsils and Adenoids _____
Others _____

Birth and Neonatal history:
Hospital: _____
Mother's age at pregnancy? _____ Any illness during pregnancy? _____
Smoking etc. if any during pregnancy? _____
Was baby born: Pre-mature On time
Type of delivery: Vaginal C-SectionOther
Birth Weight: _____
Did the baby have any problems breathing? _____

Feeding and Diet:
Breast-fed? _____ If so, for how long? _____
Formula fed? _____
Any milk intolerance as infant / other complications? _____
_____

Development and Behavior: ***APPROPRIATE / NOT (lagging behind)***

School: _____ Grade: _____

Hobbies - Sports – Social activities? _____

Sports: Basketball Baseball Football T-ball Running others
Any history of exercise induced cough or difficulty in breathing? _____

Immunizations: **Up to date / Not (lagging behind)**

Family Medical history: **HAS ANY MEMBER OF FAMILY OR CLOSE RELATIVE HAD?**
Hay fever Asthma Eczema Hives Food allergies
Cystic fibrosis Metabolic disorder Immune deficiency disorder Infant deaths
Any major illness that runs in your family in children? _____
OTHERS

Family Profile:

Are parents: *Married* *Separated* *Divorced*

Mother: Age: _____ Occupation: _____ Education: _____

Father: Age: _____ Occupation: _____ Education: _____

List brothers, sisters, their ages and if they have allergies/asthma/ major illnesses:

_____

ENVIRONMENTAL:

Does child go to Day care? _____

Do you live in: City Country/ Rural

Home Apartment Trailer home Mobile home

Number of bedrooms: _____ How old? _____ Style: _____

How many adults? _____ How many children? _____ Length of occupancy: _____

Heat: Central Space Air conditioner: Central Window unit

Humidifier: Central Separate Any water leaks/ moldy growths/ seepage/ flooding? _____

Bedroom: Box spring & mattress Waterbed Covers/Sheets: Cotton/ otherwise _____

Pillows: Feather / Non-feather Comforter /Blankets/Quilts: Feather / Non-feather

How old are pillows, mattress, blankets, and furniture _____

Furniture: Old/ Otherwise _____ Shelves: Old/ Otherwise _____

Flooring: Living room: _____ Bedroom: _____ Any rugs? _____

If carpeted, type and matting: _____

Pets: Cats/Dogs/ Others: _____ Are your pets kept: Inside/ outside

Do the pets sleep on the bed: Yes No

Any Cockroaches at home? _____ Any water bugs?

_____

Does anybody smoke? Mom: _____ Dad: _____ Grandparents: _____

Other family members: _____

If yes, do they smoke in the house or outside: _____

Does smoke bother child or worsen symptoms: _____

Are you following any environmental control measures already? _____

Are your symptoms worse anywhere in your home? ***If yes, specify location:*** _____

ARE THERE ANY MEDICAL PROBLEMS OTHER THAN ALLERGY? (REVIEW OF THE SYSTEMS)

EYES: _____

EAR, NOSE & THROAT: _____

PULMONARY :(Lungs) _____

ALLERGY/IMMUNOLOGICAL: _____

SKIN: _____

CONSTITUTIONAL SYMPTOMS: (Fever, weight loss etc) _____

CNS: (Brain and Nerves) _____

CARDIAC: (Heart, Elevated blood pressure, High cholesterol etc) _____

GI: (Stomach, esophagus, intestines etc) _____

GU: (Urinary etc) _____

HEM/ONC/LYMPHATICS: (Cancer etc) _____

INFECTIOUS: (Infections etc) _____

MULCULOSKELETAL/RHEUMATOLOGIC: (Bones & Joints) _____

PSYCHIATRIC: _____

ENDOCRINE: (Thyroid, Diabetes etc) _____

ANYTHING ELSE, WHICH HAS NOT BEEN DISCUSSED? (Do you have any other concerns?)