

Pediatric Allergy & Immunology New Patient Packet

Appointment Details:

Date: _____

Time: _____

Please arrive 20 minutes early to allow time for parking and check-in

Provider: _____

Location: Strong Memorial Hospital, AC6, 6th Floor, Pediatric Specialties (see additional directions on last page)
601 Elmwood Avenue Rochester NY, 14642

Please allow at least 2 hours for the appointment. If you have any general questions or are unable to make it to the appointment, please call our office at **585-276-7190** at least 24 hours prior to the scheduled visit.

We would like to encourage you to sign up for **My Chart** prior to your appointment which allows you to check labs, request appointments or submit questions and requests to us securely via a patient portal. You can enroll by visiting <https://mychart.uroc.rochester.edu/mychart/> or by calling 585-275-8762 or 888-661-6162.

Your child must be off the following medications for skin testing:

- Diphenhydramine (Benadryl) - 3 days prior to appointment
- Atarax, vistaril (Hydroxyzine) - 14 days prior to appointment
- Cetirizine (Zyrtec), loratadine (Claritin), fexofenadine (Allegra), levocetirizine (xyzal), desloratadine (clarinex) - 5 days prior to appointment
- Periactin (cyproheptadine) – 5 days prior to appointment. Please check with prescribing physician before stopping.
- Astelin, Astepro, Dymista (azelastine) nasal spray – 5 days prior to appointment
- Pataday, patanol (olopatadine) eye drops – 2 days prior to appointment

In the event of emergency or to control allergic/asthma symptoms, please do not hesitate to use the above medications as prescribed. Please let us know if one of these medications were given.

If your child takes oral antihistamines (e.g., Allegra, Atarax, Benadryl, Zyrtec, or Claritin) on a regular basis, stopping these medications may result in increased symptoms, please discuss alternative medications with your child's doctor.

Please let us know if your child is taking the following medications:

- Asthma rescue medications such as albuterol, xopenex, Symbicort - within 48 hours of appointment
- Oral steroids such as prednisone - within 10 days of appointment
- Antibiotics - within 5 days of appointment

In the case that your child is taking the above medications, please **DO NOT** stop administering them as prescribed.

The following medications should NOT need to be stopped:

- * Daily asthma medications (inhaled corticosteroids (flovent, asmanex, qvar), Symbicort, Singulair, Intal)
- * Nasal steroid sprays such as Nasonex, Flonase, or Rhinocort

Patient Questionnaire

Patient's Name: _____

Date of birth: _____

Reason for today's visit: _____

Past Medical/Surgical History:

Please indicate if any of the following diagnoses have been made for your child:

<input type="checkbox"/> Allergic rhinitis (hay fever)	<input type="checkbox"/> Drug allergy	<input type="checkbox"/> Hives
<input type="checkbox"/> Allergic cough	<input type="checkbox"/> Ear infections (recurrent)	<input type="checkbox"/> Immune deficiency
<input type="checkbox"/> Angioedema	<input type="checkbox"/> Eosinophilic esophagitis	<input type="checkbox"/> Stinging insect allergy
<input type="checkbox"/> Asthma/Reactive airways	<input type="checkbox"/> Esophageal reflux disease	<input type="checkbox"/> Nasal polyps
<input type="checkbox"/> Atopic dermatitis/Eczema	<input type="checkbox"/> Food allergy	<input type="checkbox"/> Lupus/Rheumatologic diseases
<input type="checkbox"/> Bronchiolitis/Bronchitis	<input type="checkbox"/> Frequent upper respiratory infections	<input type="checkbox"/> Pneumonia
<input type="checkbox"/> Contact dermatitis		<input type="checkbox"/> Sinusitis (chronic)

Please indicate if your child has had any of the following surgeries:

Tonsillectomy Adenoidectomy Sinus Surgery Ear Tubes

Has your child seen an allergist before? Yes No

*If yes, name of doctor _____

Has your child had blood or skin testing for allergies before? Yes No

* If yes, please bring test results to appointment

All Current Medications: Please list name of medication, dose and frequency

Immunizations:

Are you child's immunizations up to date? Yes No

Have there been any adverse reactions to immunizations? Yes No

*If yes, please explain _____

Birth History:

Gestational age: _____ Delivery method: Vaginal C-Section

Complications during pregnancy/delivery/neonatal period? Yes No

*If yes, please explain: _____

Social History:

Does the child attend daycare/school? Yes No

School Name _____ Grade _____

Who lives at home with the child? _____

Environmental History:

Pets: Yes No *If yes, what type: _____

Pest infestation at home? Yes No *If yes, what type: _____

Is there smoke exposure (of any type) at home or at daycare/caregiver's home? Yes No

*If yes, please share additional details _____

Review of Systems:

Is your child currently experiencing any of the following symptoms:

- | | | |
|---|--|---|
| <input type="checkbox"/> Runny nose | <input type="checkbox"/> Wheezing | <input type="checkbox"/> Vomiting |
| <input type="checkbox"/> Nasal congestion | <input type="checkbox"/> Cough | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Itchy eyes/nose | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Abdominal pain |
| <input type="checkbox"/> Sneezing | <input type="checkbox"/> Chest tightness | <input type="checkbox"/> Blood in stool |
| <input type="checkbox"/> Hoarse voice | <input type="checkbox"/> Poor growth/weight gain | <input type="checkbox"/> Fever |
| <input type="checkbox"/> Post-nasal drip | <input type="checkbox"/> Difficulty swallowing | <input type="checkbox"/> Rash/hives |
| <input type="checkbox"/> Snoring | <input type="checkbox"/> Reflux/Heartburn | <input type="checkbox"/> Headache |

Family History:

	Food allergy	Environmental allergies	Asthma	Eczema	Eosinophilic esophagitis	Bee sting / Venom Allergy	Immune deficiency	Lupus/ rheumatologic disease	Recurrent infections	Sinusitis	Thyroid disease	Other
Mother												
Father												
Sister												
Brother												
Other												

For food allergies, please specify what foods and symptoms:

Food Allergy History: If none, please skip to next section

Food	Age of child at time of reaction	Amount of food	Skin contact or ingestion	Symptoms of reaction

What foods (if any) are excluded from your child's diet?

Eczema/Atopic Dermatitis History: If none, please skip to next section

How often does your child take a bath/shower? _____

What soap/cleaner do your child use? _____

What moisturizer does your use and how often? _____

What eczema medications does your child use and how often? _____

Is there daytime or nighttime itching? Yes No

What have you used to control itching? _____

Has the skin ever been infected, requiring antibiotics? Yes No

Environmental Allergy History: If none, please skip to the next section

Does your child have allergic symptoms during certain seasons or all year round? _____

*If seasonal, circle which seasons? Spring Summer Fall Winter

Does your child have allergic symptoms after exposure to animals? Yes No

*If yes, which animal and symptoms? _____

Has your child received allergy shots before? Yes No

*If yes, when and for how long? _____

Asthma History (coughing, wheezing, shortness of breath): If none please skip to the next section

Does your child have a known diagnosis of asthma? Yes No

*If yes, what was his/her age at time of diagnosis? _____

Triggers for asthma symptoms (circle all that apply): Cold Heat Exercise Illness Animals

1. How often does your child experience coughing, wheezing or shortness of breath?	Never	2 times a week or less	More than 2 times a week	Everyday	Several times a day
2. How often does your child wake up from sleep due to symptoms?	Never	2 times a month or less	3-4 times a month	More than once a week	Every night
3. How frequently does he/she use a rescue inhaler/nebulizer?	Never	2 days a week or less	More than 2 days a week	Everyday	Several times a day
4. Do breathing symptoms cause any limitation with activity?	-	No	Minor	Some	Very limited
5. How many times per year does your child have exacerbations requiring oral steroids?	-	0-1 time a year	2 times a year	3 times a year	More than 3 times a year

Has your child ever been prescribed an inhaler? Yes No

Has your child ever been hospitalized for respiratory symptoms? Yes No

Has your child ever been in the intensive care unit (ICU)? Yes No

Has your child ever been intubated (breathing tube) for asthma? Yes No

Drug Allergy History: If none, please skip to next section

Drug name	Date or age of child at reaction	Symptoms

Bee Allergy History: If none, please skip to the next section

Has your child had a suspected allergic reaction to an insect sting? Yes No

*If yes, please explain: _____

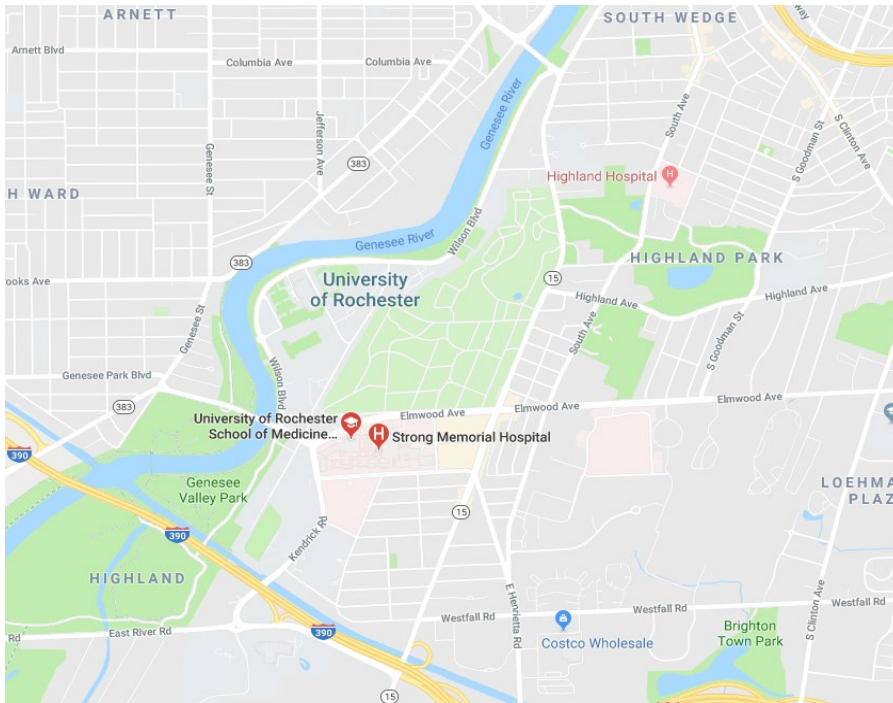
Frequent Infection History: If none, please leave blank

Does your child have recurrent infections? Yes No

*If yes, please list type and how often: _____



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From the South and Thruway (Exit 46):

Take I-390 North to Exit 16(W. Henrietta Rd.) then turn right on W. Henrietta Rd. (Rt 15). Proceed two miles and make a left turn on Elmwood Ave. The parking garage will be on the left.

From the North:

Take I-390 South to Exit 16(W. Henrietta Rd.) then turn left on W. Henrietta Rd. (Rt 15). Proceed two miles and make a left turn on Elmwood Ave. The parking garage will be on the left.

From the Parking Garage to the Pediatric Specialties Office:

Take the garage elevators to the 1st floor. As you enter the hospital, walk straight ahead to the silver elevators, which are on the left, and take the elevators to the sixth floor and proceed to **Suite B**.

By bus

You will enter the bus entrance of Strong Memorial Hospital (Elmwood Ave.), go left, take the first right to the silver elevators, take the elevators to the sixth floor, and proceed to **Suite B**.

If you are arriving by car, it is best to park in the ramp garage.

<u>Time</u>	<u>Rate</u>
0-30 Minutes	FREE
31 - 60 Minutes	\$3.00
61 Minutes - 2 Hours	\$5.00
2 Hours – 24 Hours	\$6.00