Pediatric Allergy & Immunology New Patient Packet

Appointment Details:

Date: _____

Time: _____
Please arrive 15 minutes early to allow time for parking and check-in

Provider: _____

Location: The Schottland Family YMCA - 1st Floor, off main entrance
2300 West Jefferson Road, Pittsford, NY 14534

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 schedule 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.urmc.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), desloratdine (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:

____Allergic rhinitis (hay fever)	____Drug allergy	____Hives
____Allergic cough	____Ear infections (recurrent)	____Immune deficiency
____Angioedema	____Eosinophilic esophagitis	____Stinging insect allergy
____Asthma/Reactive airways	____Esophageal reflux disease	____Nasal polyps
____Atopic dermatitis/Eczema	____Food allergy	____Lupus/Rheumatologic diseases
____Bronchiolitis/Bronchitis	____Frequent upper respiratory	____Pneumonia
____Contact dermatitis	infections	____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 has 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:

____Runny nose	____Wheezing	____Vomiting
____Nasal congestion	____Cough	____Diarrhea
____Itchy eyes/nose	____Shortness of breath	____Abdominal pain
____Sneezing	____Chest tightness	____Blood in stool
____Hoarse voice	____Poor growth/weight gain	____Fever
____Post-nasal drip	____Difficulty swallowing	____Rash/hives
____Snoring	____Reflux/Heartburn	____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: _____