PATIENT/FAMILY QUESTIONNAIRE

This questionnaire will help us learn important medical information about you and your family so we can focus our evaluation and testing appropriately.

PATIENT/FAMILY MEDICAL HISTORY

Patient name _____ DOB ____/____/____

Person filling out form ☐ Patient ☐ Other (relationship to patient) _____ Today's Date ____/____/____

Reason for coming to the clinic (problems, symptoms, etc.) _____

Current medications and/or supplements _____

_____

Allergies to medications _____

Patient's occupation ☐ Works at _____ ☐ Retired from _____ ☐ Student in _____ grade

Have you been treated or tested for allergies before? ☐ No ☐ Yes (when?) _____

Have you had a strong reaction to allergy treatment or testing? ☐ No ☐ Yes (please explain) _____

Family Medical History	PATIENT	MOTHER	FATHER	GRANDPARENTS	SIBLINGS	AUNTS/UNCLES
Major illnesses (describe)						
Allergies (describe)						

Additional family medical information _____

How much alcohol do you drink per day? _____oz. beer; _____oz. wine; _____oz. liquor

Do you use tobacco? ☐ No ☐ Yes (explain type & amount used per day) _____

ENVIRONMENTAL FACTORS (Tell us about the environments in which you spend time)

Average hours spent per day at:	Home ____	Work ____	School ____	Daycare ____	Other ____
How many years have you lived/been going to this bldg?					
Location (city, residential, industrial, town, rural, farm)					
Carpeting (shag, short pile, wall-to-wall, partial; & age)					
Has there been water damage to this building (yes/no)?					
Dust or bug problems in this building (roaches, other)?					
Pets in this building (dog, cat, bird, hamster, etc.)?					

Comments to explain any items further _____

Check the things in your environment that make you feel unwell (list specific products or items AND describe your symptoms):

☐ Pets/animals _____ ☐ Down/feathers _____

☐ Other _____ ☐ Grass/pollen/trees _____

☐ Moldy areas/things _____

MISCELLANEOUS INFORMATION

How good is your sense of smell? ☐ Above average ☐ Average ☐ Below average ☐ None/gone (how long?) _____

Do you feel worse during certain times of the year? ☐ No ☐ Yes – What season? ☐ Winter ☐ Spring ☐ Summer ☐ Fall

Are you exposed regularly to? ☐ Livestock ☐ Crops/fieldwork

How many days of work or school did you miss last year (if applicable)? _____ days. Primary reason: _____

What precautions do you take for perceived allergy problems (pillow covers, air cleaners, etc.)? _____

ADDITIONAL COMMENTS

Please include any other information that would be useful in understanding this patient's history: _____

_____

_____

_____

_____

DIET

List foods that give you problems and describe the symptoms _____

_____

List any foods you avoid and why _____

_____

Are you on a special diet? ☐ No ☐ Yes (please describe) _____

How many meals each week do you eat at:

Home ____; Fast food restaurants ____; Other restaurants ____; School ____; Pack at home/eat elsewhere _____

What foods do you eat on a typical day for:

Breakfast _____

Lunch _____

Dinner _____

What are your favorite three everyday foods? 1) _____ 2) _____ 3) _____

Are you a vegetarian? ☐ No ☐ Yes

Circle the number of servings you eat each *week* from these categories:

Wheat products (bread, pasta, pizza, cookies, breakfast cereals)	1	2	3	4	5	6	7	8+
Corn products (popcorn, lunch meat, chips/tacos, cereals)	1	2	3	4	5	6	7	8+
Other grains (rice, oats, oatmeal)	1	2	3	4	5	6	7	8+
Dairy products (milk, cheese, yogurt, ice cream, butter)	1	2	3	4	5	6	7	8+
Yeast (mushrooms, vinegar, salad dressing, soy sauce, raisins, ketchup, mustard)	1	2	3	4	5	6	7	8+
Red meats (beef, hamburger, steak, pork, ham, bacon, sausage)	1	2	3	4	5	6	7	8+
Other proteins (chicken, turkey, fish, seafood, hot dogs)	1	2	3	4	5	6	7	8+
Eggs (of any kind; also products containing eggs like mayonnaise)	1	2	3	4	5	6	7	8+
Fruits (apples, bananas, oranges, pears, melon, grapes, grapefruit, tomatoes)	1	2	3	4	5	6	7	8+
Vegetables (broccoli, beans, cabbage)	1	2	3	4	5	6	7	8+
Peanut products (including peanut butter) or soy products (tofu, soy sauce)	1	2	3	4	5	6	7	8+
Snack foods (potato chips, nuts other than peanuts, chocolate, candy, sugar substitute)	1	2	3	4	5	6	7	8+
Beverages (coffee, tea, soda/pop, diet soda)	1	2	3	4	5	6	7	8+

PEDIATRIC PATIENT INFORMATION

Were there problems during the child's ☐ prenatal period ☐ delivery ☐ postnatal period

If yes, please explain _____

Did the child have colic as a baby? ☐ No ☐ Yes

Was the child breastfed exclusively? ☐ No ☐ Yes (how many mos?) ____; Is the child on a restricted diet? ☐ No ☐ Yes

Did the child's mother drink milk while nursing the child? ☐ No ☐ Yes

Was the child fed formula? ☐ No ☐ Yes (explain any problems tolerating formula) _____

How old was the child when supplemental feeding began? ____ months; How old when solid foods were fed? ____ months

Were/are there foods that bother the child: ☐ No ☐ Yes (please explain) _____

Has the child's physical development been normal? ☐ No ☐ Yes

Current height ____ feet ____ inches (% of normal ____); Current weight ____ pounds (percentile of normal ____)

Are the child's immunizations current? ☐ Yes ☐ No (please explain) _____

How many infections has the child had in the last three months? _____; In the last year? _____

Does the child have any chronic or recurring infections? ☐ No ☐ Yes (please explain) _____

List any unusual or serious infections the child has ever had (meningitis, pneumonia, etc.) _____

_____

Patient Allergy Screening Questionnaire

Please help us understand the extent of your allergies and how it impacts your daily life. Select your response below and write the number(s) corresponding with your answer on the line.

Do you have allergies?

_____ Not sure (0)

_____ Yes, self-diagnosed (1)

_____ Yes, diagnosed by medical provider (2)

_____ Yes, self-diagnosed & confirmed by medical provider (2)

What kind of allergy or related conditions do you have? (Include all that apply)

_____ Seasonal pollen allergy like trees, grass, weeds (1)

_____ Year-round airborne allergy like mold, animals, dust mite (1)

_____ Food allergy (2)

_____ More than one food allergy (1)

_____ Asthma (2)

_____ Chronic cough lasting weeks or longer (2)

_____ Wheezing/shortness of breath (2)

_____ Eczema/chronic skin rashes (2)

_____ Hives/angioedema (swelling in skin/mucous membranes) (3)

_____ Sinusitis/chronic sinus infections two or more times/year (2)

_____ Chronic ear infection two or more times/year (2)

_____ Eosinophilic esophagitis (3)

_____ Itchy/red/watery eyes (1)

_____ Anaphylaxis (4)

_____ Stinging insects (1)

_____ Allergy to medications (1)

How are you currently treating your allergies? (Include all that apply)

_____ Over-the-counter medications like antihistamines, skin creams, etc. (1)

_____ Prescription medications like inhalers or topical steroids (2)

_____ Biologics like Dupixent, Xolair, Nucala, Eucrisa (3)

_____ Allergy Immunotherapy – shots, drops or tablets (1)

_____ Stopped allergy immunotherapy due to reactions (2)

_____ Avoiding allergy triggers using air filters, pillow/mattress covers, etc. (2)

_____ Other _____

For practice use only _____

© 2021 Allergychoices, Inc. Onalaska, WI. ALL RIGHTS RESERVED.

During the past seven days, how much did your allergy-related problem affect your productivity while you were working?

Think about days you were limited in the amount/kind of work you could do, days you accomplished less than you'd like, or could not do work as carefully as usual.

_____ Not troubled (0)
_____ Hardly troubled at all (1)
_____ Somewhat troubled (1)
_____ Moderately troubled (2)
_____ Quite a bit troubled (2)
_____ Very troubled (3)
_____ Extremely troubled (3)
_____ N/A (0)

During the past seven days, how much did your allergy-related issues affect your ability to do regular daily activities other than work at a job or school?

By regular activities, we mean activities like housework, shopping, childcare, exercise, studying, etc.

_____ Not troubled (0)
_____ Hardly troubled at all (1)
_____ Somewhat troubled (1)
_____ Moderately troubled (2)
_____ Quite a bit troubled (2)
_____ Very troubled (3)
_____ Extremely troubled (3)
_____ N/A (0)

For practice use only _____

FOR STAFF USE

Total Score: _____

© 2021 Allergychoices, Inc. Onalaska, WI. ALL RIGHTS RESERVED.

Lake Country
PEDIATRICS S.C.
independent . integrated . dedicated

Allergy Skin Test Consent

Allergy skin testing is an important diagnostic tool used by medical providers to accurately diagnose the source of allergic reaction. Correct diagnosis through testing that identifies the specific antigens causing your symptoms is an important first step to providing you with the best and most complete range of treatment options.

By managing allergic conditions, you may reduce the number of days you miss work or school, and you may eliminate (or lessen the severity of) symptoms such as attention deficit and impaired ability to concentrate.

The skin test is performed by the same process used in an allergist's office: placement of multiple antigens on the back or other body part, to be determined by your provider, with a plastic skin test applicator. This test is extremely accurate and results are read in 15 minutes.

There is a low risk of persistent itching or discomfort, and an extremely low risk of anaphylaxis associated with skin testing.

The cost of test varies by health plan, but most health plans cover the test in-network. Please note that insurance deductibles, co-insurance and co-payments may apply. If the test is not covered by your insurance plan, you will be responsible for the cost of the test.

Please confirm that you understand the reasons for the test as well as the potential benefits and risk involved:

Date_____ Time_____
Patient Name_____
Signature of Patient or Parent/Guardian_____
Name of Parent/Guardian_____

©2012