

New Patient Intake Form

Pediatric Lung and Allergy Center

Division of Fairfax Neonatal Associates, P.C.

2730-A Prosperity Avenue, Fairfax, VA 22031

Telephone (703) 289-1410 Fax (703) 289-1420

Patient name: _____ Age: _____ Today's date: _____

Chief symptom: _____ Date symptoms started: _____

SYMPTOMS:

- | | | | |
|----------------------------------|---|---|---|
| Eyes | <input type="checkbox"/> Itching | <input type="checkbox"/> Redness | <input type="checkbox"/> Tearing/Watering |
| Ears | <input type="checkbox"/> Itching | <input type="checkbox"/> Popping | <input type="checkbox"/> Fluid <input type="checkbox"/> Clicking |
| Throat | <input type="checkbox"/> Itching | <input type="checkbox"/> Throat clearing | |
| Nose | <input type="checkbox"/> Congestion
<input type="checkbox"/> Nose rubbing | <input type="checkbox"/> Runny nose
<input type="checkbox"/> Post nasal drip | <input type="checkbox"/> Sneezing <input type="checkbox"/> Itching |
| Skin | <input type="checkbox"/> Eczema
<input type="checkbox"/> Contact dermatitis | <input type="checkbox"/> Atopic dermatitis
<input type="checkbox"/> Poison Ivy | <input type="checkbox"/> Hives: <input type="checkbox"/> In the past <input type="checkbox"/> Now |
| Gastrointestinal | <input type="checkbox"/> Heartburn | <input type="checkbox"/> Burping | <input type="checkbox"/> Nausea/vomiting <input type="checkbox"/> Diarrhea |
| Cough | <input type="checkbox"/> Waking up in the AM
<input type="checkbox"/> Dry
<input type="checkbox"/> Every day | <input type="checkbox"/> Throughout the day
<input type="checkbox"/> Produces sputum
<input type="checkbox"/> 3x a week | <input type="checkbox"/> Awakened at night <input type="checkbox"/> With exercise
<input type="checkbox"/> Once a week <input type="checkbox"/> Once a month |
| Shortness of breath | <input type="checkbox"/> Awakened at night
<input type="checkbox"/> Age of onset _____ | <input type="checkbox"/> While resting
<input type="checkbox"/> Relieved by: _____ | <input type="checkbox"/> With exercise |
| Wheezing/ chest tightness | <input type="checkbox"/> Awakened at night
<input type="checkbox"/> Every day
<input type="checkbox"/> Relieved by: _____ | <input type="checkbox"/> 3x or more a week | <input type="checkbox"/> Once a week <input type="checkbox"/> Once a month |
| Asthma | <input type="checkbox"/> Ever diagnosed?
<input type="checkbox"/> Admitted to ICU for asthma | <input type="checkbox"/> Oral steroids for asthma | <input type="checkbox"/> ER visits for asthma ____ <input type="checkbox"/> Hospitalized for asthma |
| Other | <input type="checkbox"/> Mouth breathing | <input type="checkbox"/> Snoring | <input type="checkbox"/> Frequent bronchitis <input type="checkbox"/> Headaches |

PRIMARY SYMPTOMS ARE WORSE WITH:

- | | | | | |
|--|-----------------------------------|--|---|-----------------------------------|
| <input type="checkbox"/> Spring | <input type="checkbox"/> Summer | <input type="checkbox"/> Fall | <input type="checkbox"/> Winter | <input type="checkbox"/> All year |
| <input type="checkbox"/> School/work days | <input type="checkbox"/> Home | <input type="checkbox"/> Vacations | | |
| <input type="checkbox"/> Weather change | <input type="checkbox"/> Indoors | <input type="checkbox"/> Outdoors | <input type="checkbox"/> Feathers | |
| <input type="checkbox"/> Humidity | <input type="checkbox"/> Heat | <input type="checkbox"/> Cold air | <input type="checkbox"/> Windy days | |
| <input type="checkbox"/> Tobacco smoke | <input type="checkbox"/> Perfumes | <input type="checkbox"/> Irritants | <input type="checkbox"/> Flowers | |
| <input type="checkbox"/> Cats | <input type="checkbox"/> Dogs | <input type="checkbox"/> Horses | <input type="checkbox"/> Other pets | |
| <input type="checkbox"/> Moldy/musty areas | <input type="checkbox"/> Dust | <input type="checkbox"/> Stuffed animals | <input type="checkbox"/> Emotion/stress | |

PRIMARY SYMPTOMS ARE BETTER WITH:

- Air conditioning Travel away from home
- Medication including _____
- Other _____

INFANCY:

- Normal pregnancy/labor/delivery Abn. pregnancy _____ Abn. labor/delivery _____
- Breast fed for ____ months Formula fed with _____ Colic

FAMILY HISTORY:

	Mother	Father	Sister(s)	Brother(s)
<u>Asthma</u>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<u>Allergies/Hayfever</u>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<u>Food Allergy</u>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<u>Drug Allergy</u>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

New Patient Intake Form

FOOD ALLERGY:

- Patient does not have any food allergy or intolerance.
 Patient has allergic or adverse reactions to:
- | | | | |
|--|------------------------------------|--------------------------------|--|
| <input type="checkbox"/> Milk | <input type="checkbox"/> Egg | <input type="checkbox"/> Wheat | <input type="checkbox"/> Soy |
| <input type="checkbox"/> Peanut | <input type="checkbox"/> Tree nuts | <input type="checkbox"/> Fish | <input type="checkbox"/> Shellfish |
| <input type="checkbox"/> Patient has had a life threatening reaction to: _____ | | | <input type="checkbox"/> Patient has an Epi-Pen. |

DRUG ALLERGY: Please check box if patient has had any allergic or adverse reactions to these medications:

- | | |
|---|---|
| <input type="checkbox"/> Penicillin, Amoxicillin, Ampicillin | <input type="checkbox"/> Cephalosporins (Ceclor, Ceftin, Cefzil, Keflex, Omnicef, etc) |
| <input type="checkbox"/> Erythromycin (i.e. E-mycin, Biaxin, Zithromax) | <input type="checkbox"/> Sulfa-based antibiotics (Bactrim, Septra) |
| <input type="checkbox"/> Tetracycline (i.e. Doxycycline, Minocycline) | <input type="checkbox"/> Quinolones (i.e. Cipro, Levaquin, Avelox) |
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Non-steroidal anti-inflammatory drugs (i.e. Motrin, Advil, Ibuprofen, Aleve) |
| <input type="checkbox"/> Decongestants (i.e. Sudafed) | |
| <input type="checkbox"/> Other _____ | |

RECURRENT AND CHRONIC INFECTIONS:

- | | |
|--|--|
| <input type="checkbox"/> Frequent sinus infections. How many per year? _____ | <input type="checkbox"/> Sinus surgery. When? _____ |
| <input type="checkbox"/> Frequent ear infections. How many per year? _____ | <input type="checkbox"/> Ear tubes have been placed. When? _____ |
| <input type="checkbox"/> Pneumonia <input type="checkbox"/> X-ray did show pneumonia | <input type="checkbox"/> Tonsillectomy and/or adenoidectomy. When ___? |
| <input type="checkbox"/> Abscesses of skin or frequent skin infections or abscesses of internal organs | <input type="checkbox"/> Bone or joint infections |

SOCIAL AND ENVIRONMENTAL HISTORY:

- Main residence:** Single family home Townhouse Apartment/Condo Trailer
Number of years lived in present home? _____
Age of home? _____
 In a woody place In a sunny place
 Previous owners had: Dog Cat
 Fireplace Wood stove Smoker (s) in house
Bath soap _____ Shampoo _____ Laundry detergent _____ Dryer sheets are used.
- Home heating:** Central gas forced air Central electric forced air Central gas and electric Oil fired hot water heating
 Baseboard heat Radiator heat
- Central electrostatic air filter Central electronic air filter
 Filter is changed regularly Filter is washed regularly
- Home flooring:** Mostly wall to wall carpeting Mostly hard surface flooring (wood, tile, linoleum, etc)
- Pets:** Cats _____ Dogs _____ Birds Hamsters/Gerbils
- Pests:** Mice Cockroaches
- Patient's bedroom:**
 Wall to wall carpet Curtains Blinds
 Humidifier Ceiling fan HEPA filter
 Stuffed animals Stuffed animals in bed Stuffed animals washed regularly
 Dog enters bedroom Dog sleeps on bed Cat enters bedroom Cat sleeps on bed
 Regular mattress Feather mattress Feather pillow Bunk Bed
Dust mite/allergen proof covers are on: Mattress Pillows Box spring

PREVIOUS ALLERGY EVALUATIONS/TREATMENTS:

- Have you been skin tested for allergies? What year? _____ Where? _____
Have you had blood tests for allergies? What year? _____
Have you taken allergy shots? When? _____ How long? _____ Shots helped Shots did not help
Patient would like to receive allergy shots again for the first time.

CURRENT AND PAST MEDICAL PROBLEMS:

- Patient has no other active or past medical problems. _____
 _____ _____

CURRENT AND PREVIOUS MEDICATIONS:

- | | | |
|--------------------------------|--------------------------------|--------------------------------|
| <input type="checkbox"/> _____ | <input type="checkbox"/> _____ | <input type="checkbox"/> _____ |
| <input type="checkbox"/> _____ | <input type="checkbox"/> _____ | <input type="checkbox"/> _____ |

*** **Please bring ALL current medications with you to your appointment.** ***