New Patient Intake Form

Pediatric Lung and Allergy Center

Division of Fairfax Neonatal Associates, P.C.

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

Chief symptom: _____ **Date symptoms started:** _____

SYMPTOMS:

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

PRIMARY SYMPTOMS ARE WORSE WITH:

☐ Spring	☐ Summer	☐ Fall	☐ Winter	☐ All year
☐ School/work days	☐ Home	☐ Vacations		
☐ Weather change	☐ Indoors	☐ Outdoors	☐ Feathers	
☐ Humidity	☐ Heat	☐ Cold air	☐ Windy days	
☐ Tobacco smoke	☐ Perfumes	☐ Irritants	☐ Flowers	
☐ Cats	☐ Dogs	☐ Horses	☐ Other pets	
☐ Moldy/musty areas	☐ Dust	☐ Stuffed animals	☐ 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)
Asthma	☐	☐	☐	☐
Allergies/Hayfever	☐	☐	☐	☐
Food Allergy	☐	☐	☐	☐
Drug Allergy	☐	☐	☐	☐

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FOOD ALLERGY:

☐ Patient does not have any food allergy or intolerance.
☐ Patient has allergic or adverse reactions to:

☐ Milk ☐ Egg ☐ Wheat ☐ Soy
☐ Peanut ☐ Tree nuts ☐ Fish ☐ Shellfish
☐ Patient has had a life threatening reaction to: _____ ☐ Patient has an Epi-Pen.

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

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

RECURRENT AND CHRONIC INFECTIONS:

☐ Frequent sinus infections. How many per year? _____
☐ Frequent ear infections. How many per year? _____
☐ Pneumonia ☐ X-ray did show pneumonia
☐ Abscesses of skin or frequent skin infections or abscesses of internal organs
☐ Sinus surgery. When? _____
☐ Ear tubes have been placed. When? _____
☐ Tonsillectomy and/or adenoidectomy. When__?
☐ 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:

☐ _____ ☐ _____ ☐ _____
☐ _____ ☐ _____ ☐ _____

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