ALLERGIES
Any Allergy Symptoms? Please Circle:
- Itchy or Red Eyes
- Eye swelling
- Stuffy nose
- Runny nose
- Itchy nose
- Sneezing
- Snoring
- Post-nasal drip
- Bloody nose

Does your child have any reactions to the following?
- Food
- Insect Stings
- Latex/Rubber
- Antibiotics
- Medicine
- Aspirin
- Ibuprofen

When do these symptoms bother your child?
- Spring
- Summer
- Fall
- Winter

What medications do you use?

Have you seen an allergist in the past? Yes / No

Have you been tested for allergies? Yes / No

BREATHEING
Was your child hospitalized for asthma in the past year? Yes / No

Has your child gone to the ER for asthma in the past year? Yes / No

Last time oral steroids were used for asthma (if applicable): __________

SKIN
Any Skin Symptoms?
- Eczema/Atopic Dermatitis
- Hives
- Itchy Skin
- Other Skin Condition:

ENVIRONMENT
Any smokers inside or outside your home? Yes / No

Fireplace or wood burning stove?

Any Chest Symptoms in the past 6 months?
- Asthma
- Trouble Breathing or Cough with Exercise
- Cough
- Wheezing
- Chest Tightness

MEDICAL HISTORY
Does your child have a history of the following?
- Ear Infections
- Sinus Infections
- Pneumonia
- Skin Infections
- Autoimmune Diseases (e.g.,: Arthritis, Lupus, Thyroid Disease, Low Blood Counts)
- Surgeries (please describe):

FAMILY HISTORY
Does anyone in your family have the following?
- Asthma
- Seasonal Allergies
- Eczema
- Food Allergy
- Autoimmune Diseases (describe)

REVIEW OF SYSTEMS
****Over the past 3 months has your child had any of the following symptoms? If not, circle “NONE.”***

Parent Signature: ____________________________________________  Reviewed by: ___________________ Date: ___________