Allergy & Asthma Consultants of Mid-Michigan, P.C.

Ridhu C. Burton, M.D.
James H Saker, M.D.
Clyde R. Flory, M.D.
Diplomates of the American Board
Allergy & Clinical Immunology

4169 Legacy Parkway
Lansing, MI 48911
Phone (517) 394-6500
Fax (517) 393-4202

Pediatric Medical History

How did you hear about our office?

____Referral by another physician ____Referral by another patient
____Phonebook listing _____ Internet Ad; Please circle one Google, Bing or Yahoo
____Other: _____

Name:_____ DOB:_____

I. Reason for evaluation:

A. Reason your child was sent to an allergist:_____
_____

II. If patient has ASTHMA symptoms fill out the following:

A. What are your child's symptoms?
_____ Cough _____Wheeze _____Shortness of Breath

B. What age did symptoms begin?_____

C. How frequent are the symptoms?
____< 2 x per week ____> 2 x per week ____Daily

D. Any hospitalizations, urgent care or emergency room visits for asthma? _____Yes _____No
List when and where _____
_____

III. Nasal symptoms

_____Itching _____Sneezing
_____Nasal discharge
_____Nasal congestion _____Snoring _____Mouth Breathing
_____Clearing of throat _____Postnasal drainage

A. When are symptoms worse?
_____ All year _____Spring _____Summer _____Fall _____Winter

IV. Other Symptoms

Eyes: _____Itching _____Redness/tearing/discharge_____Seasonal _____Year round

Ears: _____Earaches _____Infections _____Hearing loss _____Ear tubes When?_____

Infections: How many of the following per year?
_____Colds/year _____Bronchitis/Pneumonia _____ Sinusitis
_____Ear Infections _____Tonsillitis

Skin: _____Eczema
_____Hives

V. Do foods cause any symptoms?

Name Food and Associated Symptoms

Food:_____ Symptoms:_____
Food:_____ Symptoms:_____
Food:_____ Symptoms:_____
(hives, rash, runny nose, nauseas or vomiting, diarrhea, headache)

VI. Quality of life:

A. Do symptoms affect the following:
_____School _____Work _____Missed days _____Sleep _____ Sports

VII. Growth and Development

A. Birth weight: _____
B. Breast fed: ____No _____Yes If yes, how long _____
C. Immunizations: _____Complete _____Incomplete _____ Reactions
D. Surgeries or Hospitalizations (dates if known):
1. _____ 3. _____
2. _____ 4. _____

VIII. Family History

	Father	Mother	Brothers	Sisters
Age				
Hay Fever/ Sinus Trouble				
Asthma				
Eczema				
Hives				

A. Does any illness run on either side of the family?_____

I. **Living Environment-Circle the following**

A. **Type of structure: Home Apartment Duplex Condo**
Location of Home: Country City Suburban
Proximal to: Factories Graineries Farm
Approximate age of home:_____ How long have you lived there?_____
Any smokers in residence? Yes No Exposed to Second hand smoke? Yes No

B. **Do you have any of the following: Basement Crawl Space Slab**
Type of basement: Block Poured Finished Michigan cellar
Basement in winter: Dry Damp Basement in summer: Dry Damp
Basement musty or moldy: Yes No Basement leaks with rain: Yes No
Dehumidifier in basement: Yes No Symptoms worse in basement: Yes No

C. Type of Furnace: Gas Wood Oil Electric Coal
Location of furnace: Basement Crawl space 1st floor
Heating system: Forced air Radiator Steam Fireplace Space heater
Type of Filters: Disposable Permanent Electrostatic
Central air conditioning: Yes No Room air cleaner: Yes No
Humidifier on furnace: Yes No Portable humidifier location_____
Fireplace or wood burning stove: Yes No

D. Patient's Bedroom location: Basement 1st floor Upper floor
Bedroom Floor coverings: Carpet (shag) Carpet (short pile) Wood Tile Vinyl
Living Area Floor coverings: Carpet (shag) Carpet (short pile) Wood Tile Vinyl
Bed coverings: Feather comforter _____Yes _____No
Pillow(s): Polyester Foam Feather Cotton Pillow age____ Are pillows encased? Yes No
Mattress: Cotton innerspring Foam Water Feather Mattress age_____
Is Mattress encased? Yes No Is Box Spring encased? Yes No
Pets in bedroom: Yes No

E. Is there mold growing anywhere in the house:_____

F. Is there anything in your building, yard, or around your house that has not been mentioned that you think is significant in contributing to your child's problems?_____

_____

_____

G. Is the child exposed to second hand smoke: Yes No

IX. Inhalant History

A. Dust: Dust exposure may cause either Nasal or Lung symptoms or both. With the following dust exposures, indicate which symptoms are worse by circling "N" to indicate Nasal, "L" to indicate Lung, "O" to indicate None, and "U" to indicate Unknown.

Dusty garage:	N	L	O	U	Breathing house dust:	N	L	O	U
Outdoor dust:	N	L	O	U	Dusting and/or vacuuming:	N	L	O	U
Feathers	N	L	O	U					

B. Molds: Do your symptoms worsen after exposure to the following:

Hay:	Yes	No	Unknown	Raking Leaves:	Yes	No	Unknown
Barns:	Yes	No	Unknown	Cut dried grass/fresh cut grass:	Yes	No	Unknown
Damp Basements:	Yes	No	Unknown	Eating mushrooms:	Yes	No	Unknown
				Eating cheese:	Yes	No	Unknown

C. Danders: Please indicate the number of pets you own, their age and circle whether they are indoor or outdoor.

Cat #_____ Age_____ Outdoor/Indoor/Bedroom
Dog #_____ Age_____ Outdoor/Indoor/Bedroom
Parakeet #_____ Age_____ Outdoor/Indoor/Bedroom
Other #_____ Age_____ Outdoor/Indoor/Bedroom

What animals aggravate your symptoms?_____
Any animals at child care?: Yes No If yes, what animals:_____

X. Drugs

A. Has your child ever had an adverse or allergic reaction to any medication?

Drug	Reaction	Date
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

XI. Insect Stings:

A. Has you child ever had an unusual reaction from an insect sting? Yes No
Date:_____ Type of insect: _____
Type of reaction:_____

_____

XII. Medications (this is very important)

A. List all current medications including **strength and how many times you take it**:

Med Name: Strength (i.e. mg): Frequency:

1. _____
2. _____
3. _____

4. _____

5. _____

6. _____

7. _____

8. _____

XIII. Prescription Pharmacy

1. Local Pharmacy: _____

   Address: _____

   Phone #: _____

2. Mail Order Pharmacy: _____

XV. Have you received the Flu Shot this year?

No____ Yes_____ Date:_____