Hasbro Children's Hospital
The Pediatric Division of Rhode Island Hospital
A Lifespan Partner

Hasbro Children's Hospital Allergy & Immunology New Patient History Form

Patient's Last Name	**Patient's First Name**	**Date of Birth**
Primary Care Physician/Pediatrician:	**Who referred you to the Allergy Program?** o My child's primary care provider o Self-referred o Other:_____	

Please tell us about the problem or question that brought your child to the Hasbro Children's Hospital Allergy Program:
Has your child had any special tests or procedures related to this problem (e.g. allergy testing, blood tests, X-rays, endoscopies)? If yes, please include dates of test/procedure.

MEDICAL HISTORY:

Has your child been diagnosed or suspected to have any of the following?
Asthma? o Yes o No **If yes:** Has your child been hospitalized for asthma? o Yes o No In the ICU (Intensive Care Unit)? o Yes o No Taken oral steroids? o Yes o No If yes, number of times in last year_____
Eczema? o Yes o No **If yes:** Does your child have difficulty sleeping due to itching o Yes o No Has your child had any skin infections? o Yes o No
Food Allergies? o Yes o No **If yes:** What foods are currently being restricted from your child's diet? _____ Has your child been prescribed an epinephrine auto-injector (i.e. EpiPen)? o Yes o No
Nasal/Eye Allergies? o Yes o No **If yes:** What symptoms? o Sneezing o Congestion o Post-nasal drip o Runny nose o Red itchy eyes o Other What triggers your child's symptoms? _____ What seasons are worse? o Spring o Summer o Fall o Winter o Always bad
Increased frequency/severity of infections? o Yes o No **If yes:** What type of infections? o Ear infections o Sinus Infections o Pneumonias o Bronchitis o Other_____ How many course of antibiotics has your child taken in the past 12 months?_____

Was your child born: o Full-term o Premature **Delivery:** o Via normal delivery o Via C-section
Was your child breastfed? o Yes o No If yes, for how long? _____

Has your child had any other medical problems or diagnoses? _____
_____
_____

Has your child been hospitalized or had any surgeries (If yes, please describe)?_____
_____
_____

Are your child's immunizations up to date? o Yes o No
Did your child receive the influenza vaccine ("flu shot") this year? o Yes o No

What medicines is your child currently taking?						
Medicine	**Last time given?**	**Dose**	**Taken how often?**	**How well does it work?**		
				Very Well	**Just OK**	**Not at all**
Have you previously tried any other medicines for your child's problem? If yes, please list.						
Is your child allergic to any medications or latex? Please describe:						

SOCIAL HISTORY:

Father's/Guardian's Name and Occupation:_____
Mother's/Guardian's Name and Occupation:_____
Who are the legal guardians? o Mother o Father o Both o Other_____
Sibling's Names and ages_____

Does your child attend school/daycare? o Yes o No
If yes: What grade?_____
Has your child missed any school due to illness this year? o Yes o No
If yes: How many days?_____
Does your child participate in any sports/activities?_____

ENVIRONMENTAL HISTORY:

Does your child live in: o Apartment o House o Multifamily house/condo o Other_____

Do you have a basement? o Yes o No **If Yes**: Is it o Dry o Damp o Has Flooded

Climate Control: o Hot water heat o Steam heat o Forced hot air o Wood stove o Space heater
o Central A/C o Window A/C o Air filters o Air cleaner/purifier
o Humidifier o Dehumidifier o Other

Does your home have? o Mold or mildew o Damp or musty smell o Water stains o Mice o Cockroaches

Flooring: o Hardwood o Tile/linoleum o Wall to wall carpeting o Area rugs o Other: _____

Exposure to Animals: o No o Yes (If yes, please describe):_____

Do you or any of your child's care-takers smoke? o No o Yes (who)? _____

Does your child's bedroom have? o Stuffed animals o Rugs o Carpeting o Blinds o Curtains
o Air conditioning o Humidifier o Feather pillow o Down comforter
o Air cleaner/purifier o Allergy-proof mattress or pillow covers

School, work or day care environment (please describe)_____
_____
_____

FAMILY HISTORY:

Condition	Please list all relatives with condition. (i.e. child's mother, father, brother/sister, grandfather/grandmother)
Asthma	
Nasal/Eye Allergy	
Eczema	
Food Allergy	
Chronic hives/swelling	
Drug Allergy	
Frequent infections	
Cystic Fibrosis	
Celiac Disease	
Thyroid Disease	
Other Autoimmune disease	
Other:_____	

o **No family history of any of the above**

REVIEW OF SYSTEMS:

Has your child been experiencing any of the following in the last TWO WEEKS?
Mark N/A if you are unable to assess this symptom.

	Yes	No	N/A
Constitutional			
Feeling tired			
Fevers			
Chills			
Poor weight gain			
Changes in appetite			
Ophthalmologic			
Red or itchy eyes			
Blurred or altered vision			
Sensitivity to light			
Ear/Nose/Throat			
Nasal congestion/discharge			
Snoring			
Nose bleeds			
Loss of smell			
Respiratory			
Cough			
Shortness of breath			
Wheezing			
Cardiac			
Heart racing/palpitations			
Chest pain			
Gastrointestinal			
Diarrhea			
Constipation			
Abdominal pain			
Nausea/Vomiting			
Acid reflux/heartburn			
Blood in stool			
Urinary			
Pain with urination			
Frequent urination			
Hematologic			
Easy bruising or bleeding			
Swollen glands			
Skin			
Rash			
Itching			
Endocrine			
Excessive thirst			
Hot or cold intolerance			
Delayed puberty			
Neurologic			
Headaches			
Dizziness or lightheadedness			
Weakness			
Numbness/tingling			
Seizures			
Psychiatric			
Hyperactivity disorder			
Depression			
Anxiety			
Sleep disturbances			
Musculoskeletal			
Muscle pain			
Joint pain			
Joint swelling			

Further Details or other symptoms: _____
_____
_____
_____

_____ _____

Person Completing This Form/Relationship to Patient **Reviewed by Provider** **Date**