THE Woodlands Allergy
ASTHMA & IMMUNOLOGY CENTER

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**PEDIATRIC AND ADOLESCENT ALLERGY INTAKE FORM** (ages 0-17 years)

Patient Name: _____ DOB: _____ Today's Date: _____

Primary Care Provider: _____ Referred by: _____

Preferred LOCAL pharmacy (name and location): _____
Preferred MAIL-ORDER pharmacy (name): _____

Parent's Email: _____ □ prefer not to provide

**MEDICATIONS** and **SUPPLEMENTS** currently taken: □ NONE □ See attached form

**DRUG ALLERGIES:** □ No known drug allergies

**Stinging Insect Allergies:** □ No known insect allergies

□ Bee □ Wasp □ Yellow Jacket □ Hornet □ Fire Ant REACTION: _____

**Food Allergies** (specify food and reaction): □ No known food allergies

_____

**REASON FOR VISIT:** (check all that apply)

□ Nasal or Sinus Problems □ Skin Rash/Hives □ Drug allergy

□ Chest Problems □ Food Allergies □ Insect Stings

□ Frequent infections □ Other: _____

**HAS YOUR CHILD BEEN SKIN TESTED BEFORE?** □ Yes □ No Date: _____ Results: _____
Has your child been on allergy shots/drops before? □ Yes □ No Date: _____ Effectiveness: _____

Name: _____ DOB: _____ Date: _____

**ALLERGY, ASTHMA & IMMUNOLOGY PERTINENT HISTORY**:

□ Emergency Room Visits: (per month/year) _____ Reason: _____
□ Hospitalizations: (per month/year) _____ Reason: _____
*(for asthma, allergies, swelling, or infections only)*

How long have you lived in Central Texas: _____
Where else did you live before: _____

**Home Environment:** □ House □ Condo □ Apartment □ Modular home **Years lived there**: _____
Age of home: _____ □ Air conditioning □ Forced air heat □ Carpeting in the bedroom
□ Down bedding □ Dust mite covers □ Dusty hobbies □ Animals in the home (type) _____

**PAST MEDICAL & SURGICAL HISTORY** (mark all that apply):

**Skin:** □ eczema □ hives □ swelling □ contact dermatitis □ mastocytosis □ other _____

**Head, Eyes, Ears, Nose, Throat:** □ chronic ear infections □ frequent sinus infections □ nasal polyps
□ deviated nasal septum □ nasal fracture □ tonsillitis □ contact lenses

**Chest:** □ asthma □ chronic cough □ tuberculosis □ cystic fibrosis □ sleep apnea
If YES to asthma - common triggers include: □ infections □ exercise □ allergies □ cold air □ smoke

**Immune Function:** □ seasonal allergies □ pet allergies □ frequent bronchitis □ recurrent pneumonia
□ hypogammaglobulinemia □ other immune disorder _____

**Other Medical history:** □ thyroid disease □ ADHD □ depression/anxiety □ cancer (type: _____)

**Relevant surgeries:** □ Tonsillectomy (year: _____) □ Adenoidectomy (year: _____)
□ Nasal/sinus surgery (year: _____ reasons: _____)

**FAMILY HISTORY** *of allergies, asthma or immune problems only:*

**SOCIAL HISTORY:**
Mother/guardian's name _____ Occupation: _____
Father/guardian's name _____ Occupation: _____
Siblings: _____ School grade: _____

**LIFESTYLE:**
Exercise: □ sedentary □ moderate □ vigorous Type: _____
**Smoking status**: □ current □ former □ never
Tobacco use (past or present): Type:_____ Amount: _____ Year of use: _____
**Secondhand smoke exposure:** Smokers in the home □ Yes □ No

**HEALTH MAINTENANCE:**
Vaccines: □ Flu (year_____) □ Pneumonia (year_____) □ Childhood vaccines up to date

**THANK YOU!**