Children's Hospital Boston

LABEL OR PRINT
NAME

CH MRN

ALLERGY/IMMUNOLOGY RETURN PATIENT QUESTIONNAIRE

YOUR CHILD'S MEDICAL HISTORY

☐ **Asthma** ☐ **Eczema** ☐ **Allergic Rhinitis/Sinusitis** ☐ **Food Allergies** ☐ **Recurrent Infections** ☐ **Other**

Do you feel your child's symptoms have been currently well controlled? ☐ **Yes** ☐ **No**

IF your child has food allergies, please list foods restricted: _____

_____

IF your child has asthma, has he/she needed oral steroids (e.g. Orapred, Prednisone) since the last visit? ☐ **Yes** ☐ **No**

LIST ANY MEDICATION ALLERGIES: _____

_____

Pharmacy Name: _____ **Address:** _____

Specialty Pharmacy Name: _____

WHAT MATTERS TO YOU

I want to know:

My questions are:

I don't want to leave without this (asthma or epinephrine action plan, prescription, etc):

REVIEW OF SYSTEMS – Please indicate whether your child has RECENTLY been experiencing any of these symptoms:

	Yes	No	Further Details
Feeling tired/fatigued			
Fevers			
Recent weight loss/gain			
Nasal congestion			
Post nasal drip/runny nose			
Cough			
Feeding difficulties			
Itching			
Recent infections			
Rash			
Red or itchy eyes			
Diarrhea or constipation			

SINCE THE LAST VISIT:

Are there other changes or recent illnesses in your child's health? ☐ Yes ☐ No
Has any family member been diagnosed with asthma, allergy or immune problems? ☐ Yes ☐ No
Have there been any changes in the home or school (e.g. pets, smokers, etc.)? ☐ Yes ☐ No
If you answered YES to any of these questions, please describe below:

_____

_____

_____

_____

Patient/Patient Representative Signature	Name (printed):	Relationship to patient or Patient	Time	Date