Children's Hospital of Pittsburgh of UPMC

ALLERGY / IMMUNOLOGY DEPARTMENT

Today's Date: _____ CHP.0378 Rev. 04/12

Addressograph

PATIENT NAME (Last, First, Middle)			ADDRESS		CITY, STATE, ZIP
HOME PHONE			DAYTIME PHONE	CELL PHONE	OTHER PHONE
DATE OF BIRTH	AGE	SEX ☐ MALE ☐ FEMALE	PARENT(S)/PATIENT'S OCCUPATION		
PARENT/GUARDIAN NAME(S)					
REQUESTING PHYSICIAN (Name of MD asking patient to visit Allergy/Immunology Dept.)			PRIMARY CARE PHYSICIAN		

REASON FOR VISIT (IN ORDER OF IMPORTANCE)	DRUG / FOOD ALLERGIES DRUG / FOOD — SYMPTOMS
1.	
2.	
3.	
4.	
5.	☐ No known drug allergies

FAMILY HISTORY

PLEASE CHECK IF THE PATIENT'S FAMILY MEMBERS HAVE ANY OF THE FOLLOWING

	Asthma	Allergic Rhinitis (Hayfever)	Eczema (Itchy, Red Skin)	Drug Allergies	Food Allergy	Immunodeficiency	Autoimmune Disease (Lupus)	Cystic Fibrosis
Mother								
Father								
Brother								
Sister								
Aunt								
Uncle								
Grandmother								
Grandfather								

DAILY & OCCASIONAL MEDICINES USED (Include Inhalers, Sprays, Pills, Creams, Vitamins, Herbal Medications & Dosage)	BIRTH HISTORY / IMMUNIZATIONS	OTHER SIGNIFICANT PAST MEDICAL HISTORY (Include Newborn Period, Surgeries & Hospitalizations)
	Was patient born pre-maturely? ☐ Yes ☐ No	
	If yes, how early:	
	Are immunizations current? ☐ Yes ☐ No	

(Please Complete Reverse Side)

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GENERAL	YES	NO	MUSCULO-SKELETAL	YES	NO	NERVOUS SYSTEM	YES	NO
Weight Loss	☐	☐	Joint Pain	☐	☐	Headaches	☐	☐
Exercise / Activity Intolerance	☐	☐	Joint Swelling/Redness	☐	☐	Fainting	☐	☐
Tired all the Time	☐	☐				Dizziness or Lightheaded	☐	☐
School / Work Days Missed Past Year_____						Convulsions	☐	☐

EARS	YES	NO	THROAT	YES	NO	GASTROINTESTINAL	YES	NO
Pain	☐	☐	Sore	☐	☐	Diarrhea	☐	☐
Hearing Loss	☐	☐	Clearing	☐	☐	Constipation	☐	☐
Infections	☐	☐	Bad Breath	☐	☐	Abdominal Pain	☐	☐
PE Tubes	☐	☐	Voice Change	☐	☐	Blood in Stools	☐	☐
			Swollen Glands	☐	☐	Mucous in Stools☐	☐	
NOSE	**YES**	**NO**	Itch	☐	☐			
Discharge	☐	☐	Trouble Swallowing	☐	☐	**GENITOURINARY**	**YES**	**NO**
Itch	☐	☐				Pain	☐	☐
Bleeding	☐	☐	**RESPIRATORY**	**YES**	**NO**	Itching	☐	☐
Sneezing	☐	☐	Wheeze / Cough	☐	☐	Infection	☐	☐
Mouth Breathing	☐	☐	Fall	☐	☐			
Snoring	☐	☐	Winter	☐	☐	**SKIN**	**YES**	**NO**
Stuffiness	☐	☐	Spring	☐	☐	Thrush	☐	☐
Polyps	☐	☐	Summer	☐	☐	Hives	☐	☐
Colds	☐	☐	Nighttime	☐	☐	Eczema	☐	☐
Sinusitis Requiring Antibiotics	☐	☐	With Exercise	☐	☐	Cheeks	☐	☐
Difficult Seasons:	☐	☐	Shortness of Breath	☐	☐	Bend of Elbows	☐	☐
Fall	☐	☐	Chest Pain / Discomfort	☐	☐	Behind Knees	☐	☐
Winter	☐	☐	Sputum	☐	☐	Neck	☐	☐
Spring	☐	☐				All over	☐	☐
Summer	☐	☐	**CHEST**	**YES**	**NO**			
			Chest Pain	☐	☐			
EYES	**YES**	**NO**	Palpitations	☐	☐			
Redness	☐	☐	High Blood Pressure	☐	☐			
Itch	☐	☐						
Tearing	☐	☐	**HEMATOLOGIC/LYMPHATIC**	**YES**	**NO**			
Discharge	☐	☐	Swollen nodes	☐	☐			
Puffiness	☐	☐	Anemia	☐	☐			

LIVING ACCOMMODATIONS	YES	NO	ENVIRONMENTAL/SOCIAL HISTORY	YES	NO	
House	☐	☐	Patient smoker	☐	☐	
Mobile Home	☐	☐	Smoker(s) in household	☐	☐	**Who:**
Apartment	☐	☐	Carpet in bedroom	☐	☐	
Basement	☐	☐	Pets inside home	☐	☐	**List Pets:**
Years in Home_____			Pets **always** outside	☐	☐	

List other members in your household:

Form completed by _____ **Date** _____

Relationship to Patient _____

Physician/CRNP Signature _____ **Date** _____ **Time** _____