CHILD

Allergy & Immunology New Patient Form

(over 3 years since last seen = NEW Patient) **PAGE 1 OF 2**

Cooper University Health Care

In an effort to know as much as we can about your child to assist with your visit with the Allergist/Immunologist, please complete the following two pages. When form is fully completed, please save the file and forward the attachment via email to: **allergy@cooperhealth.edu** prior to your appointment, or print and bring with you if that is easier. ***Thank you!***

Patient Name: _____ **Date of Birth:** _____

MUST FILL OUT. PLEASE TELL US THE REASON YOU BROUGHT YOUR CHILD TO SEE US TODAY:

My Child is here TODAY because: _____

PAST Medical History

Has your child ever been seen by a health care provider for any of the following: *(please check the box if YES)*

☐ Asthma	☐ Sinus problems	☐ Hives	☐ Swelling
☐ Bronchitis	☐ Ear infections	☐ Hearing loss	☐ Year-round allergies
☐ Pneumonia	☐ Eczema	☐ Acid reflux	☐ Seasonal allergies (spring/fall)

☐ Other _____

Hospitalizations: _____

Surgical History: _____

Birth History: *(only for patients under 12 years of age)* **Hospital of Birth:** _____

☐ Full term ☐ Premature ☐ C-section ☐ Vaginal delivery Birth weight: _____ lbs. _____ oz.

Breastfed ◯ Yes ◯ No

Birth Complications ◯ No ◯ Yes: _____

Previous Allergy Testing or Lab Tests? ◯ Yes: approximately what year? _____ ◯ No

Previous Chest X-ray? ◯ Yes: approximately what year? _____ ◯ No

Diet: ***Is your child able to eat the following foods?:*** *(please check the boxes)*

YES, they CAN eat: ☐ Milk ☐ Eggs ☐ Peanut ☐ Tree nuts *(all other nuts)* ☐ Shellfish ☐ Fish

Present Medications: _____

Immunizations: ☐ Up to date ☐ Delayed (behind schedule) ***Did they have the:*** ☐ Flu shot ☐ COVID vaccine

Drug Allergies: _____ **Food Allergies:** _____

Latex Allergy: *(any problems with balloons or dental procedures, etc.)* _____

Insect Sensitivity: *(bee, wasp, hornet, spider, mosquito)* ☐ Never stung ☐ Stung – No reaction ☐ Stung with reaction

Reaction: ☐ Small swelling at site ☐ Large swelling at site ☐ Hives; swelling of the lips, tongue, throat; trouble breathing

Contrast Dye Allergy: *(MRI or CT scan)* ☐ No exposure ☐ Exposed *(no reaction)* ☐ Exposed *(with reaction)*

Please complete both sides

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Family History: ***Does anyone in the family have the following?*** *(place an X if YES)*

	Asthma	Allergic rhinitis (hayfever/seasonal allergies)	Sinus problems	Food allergy	Eczema (skin problems)	Drug allergy	Other
Mother							
Father							
Siblings							

Social History: ***Patient's parent(s) are:*** *(please check box)* ☐Married ☐Divorced ☐Single

Your home is: ☐Single family ☐Apartment ☐Condo/townhouse ☐Other _____

Your neighborhood is: ☐Urban ☐Suburban ☐Farm ☐Woods ☐Lake ☐Coastal

Problems in the home with: ☐Mice/rats ☐Cockroaches

Basement: ***Do you have a basement?*** ◯Yes ◯No ***If YES, is it*** ☐Dry ☐Damp

Type of heat in your home:

☐Gas/FHA ☐Oil ☐Electric ☐Kerosene ☐Radiator ☐Baseboard ☐Fireplace ☐Wood-burning stove

In winter, we keep our home thermostat at: ☐70° ☐Less than 70° ☐Greater than 70°

My child's bedroom floor has: ☐Wall-to-wall carpeting ☐Hardwood ☐Area rug ☐Linoleum

Bed: ☐Regular bed ☐Crib ☐Other _____

Pillow: ☐Fiber filled ☐Feather ☐Foam

Pillow cover (hypoallergenic): ◯Yes ◯No

Mattress cover (hypoallergenic): ◯Yes ◯No

School: ☐Preschool ☐Elementary ☐High school ☐College

☐Frequent absenteeism (days per year): _____

Interests/activities outside of school/work: _____

Daycare *(for young children)* ◯YES Days/week: _____ ◯NO ☐Private babysitter ☐Home w/parents

Occupation: Mother: _____ Father: _____

Smoking/vaping: ***Does anyone smoke or vape in the house?*** ◯Yes ◯No ***If yes:*** ☐Mother ☐Father ☐Other

Pets: ☐None ☐Dog(s) _____ ☐Cat(s) _____ ☐Bird(s) _____ ☐Other _____

Skin Care: For eczema, dry skin, or other skin conditions

Type of soap or skin wash: _____

Type of moisturizers: _____

Laundry detergent: _____ ***Dryer sheets*** Yes◯ No◯ ***Fabric softener*** Yes◯ No◯

Skin medications: _____

If you are seeing us due to a reaction of any kind (hives, swelling, itching, etc.) to a food/drug/any other substance, please provide any pertinent information that may be helpful for the physician to determine what may have caused the reaction. For example: Foods eaten 24 hours prior to a reaction, medications, lotions, soaps, laundry detergents, pets, or outdoor allergens. Please keep in mind that if you had a reaction to a drug, we may not be able to test the specific drug. Your evaluation is of the utmost importance to us, and we will strive to find answers for you.

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Please complete both sides