CHILD

Allergy & Immunology New Patient Form

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

Cooper University Health Care

To help us know as much as we can about your child to assist with their visit with Dr. Lania, please complete the following two pages. Please complete all of the questions by placing an "X" in the box that applies, and please bring this form with you to the appointment. ***Thank you!***

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

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 ➡

CHILD

Allergy & Immunology New Patient Form

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

Cooper University Health Care

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.

Please complete both sides ➡

DIVISION OF ALLERGY-IMMUNOLOGY

Cooper University Health Care

Maria Lania-Howarth, MD, FAAAAI, FACAAI, *Division Head*
Diplomat of the American Board of Allergy and Immunology
856.325.6755

Please STOP taking these medications one week before allergy testing:

ANTIHISTAMINES

- Alavert, Claritin, Claritin-D (Loratidine)
- Allegra/Allegra-D (Fexofenadine)
- Benadryl (Diphenhydramine)
- Chlortrimeton (Chlorpheniramine)
- Clarinex (Desloratidine)
- Atarax, Vistaril (Hydroxyzine)
- Periactin (Cyproheptadine)
- Xyzal (Levocetrizine)
- Zyrtec/Zyrtec-D (Cetirizine)

ANTIHISTAMINES / Cold or Allergy Medications

- AlleRx/AlleRx-D
- Astepro/Astelin nasal spray
- Bromfed/bromphenex (Brompheneramine)
- Dimetapp (Brompheneramine)
- Duradryl D-Allergy
- Extendryl (Chlorpheniramine)
- PediaCare Cough & Cold D-Allergy
- NyQuil (Doxylamine)
- Promethazine
- Robitussin Cough & Cold
- Rondec (Carbinoxamine)
- Rynatan/Rynatuss Ryna-12 (Chlorpheniramine)
- Semprex D (Acrivastine)
- Tanafed/Tannate (Chlorpheniramine)
- Triaminic (Nighttime Cough & Cold; Cold & Allergy; Cold & Cough)
- Tussi-12 D-Allergy
- Tylenol Cold

You may CONTINUE taking these medications:

- Asthma Medications (any inhalers, Singulair/Montelukast)
- Nose Sprays
- Cough Medications (that do not contain any of the above antihistamines)
- Oral Steroids