Pediatric Partners
OF AUGUSTA

**Dr. Mary Anderson**
**Board Certified Pediatric Allergist**

## PATIENT INTAKE FORM

Date ___________________

Patient's Name_____________________________ DOB _______________

Primary Physician ____________________________ Referring Physician_______________________

## SYMPTOMS

Please circle/check any chronic symptoms you /your child may have:

Head/Neck Symptoms
Runny/stuffy nose
Bouts of sneezing
Itchy nose/throat/ear canals.
Post nasal drainage
Frequent nosebleeds
Itchy/watery eyes
Snoring
Headaches

Chest/Lung/.Breathing Symptoms
Shortness of breath
Chest tightness
Rattling in chest
Frequent cough
Wheezing
History of Asthma? Yes No

Gastrointestinal Symptoms
Frequent vomiting or diarrhea
Abdominal pain
Heartburn or ulcers
Poor Appetite

Skin Symptoms
Eczema
Hives
Skin itching
Other rash - where_________________

## SYMPTOM TRIGGERS

Please circle any you think makes your/your child's symptoms worse:

House dust Feathers Animal danders
Molds Damp areas
Tree pollen Grass cutting
Perfumes
Smoke
Exercise
Changes in temperature/humidity/cold air
Latex Sensitivity

## ENVIRONMENTAL HISTORY

Please circle or complete answers as appropriate:

Your home is a: House Apartment Mobile Home
Location City Farm Suburbs
How long have you lived there ________________ How old is the home__________________
Type of mattress Foam Innerspring Other ____________________
Floors Carpet Wood Linoleum Other________________
House is generally Dry Dusty Moist
Air Conditioning Central Window Units
Heating System Electric Gas Fuel Oil Wood
Change air filters every ____months
Any Pets? Please list number, type and whether indoor or outdoor

___________________________________________________________________________

Smokers in home Yes No How many____________
How many people in household _____________________

## BIRTH HISTORY

Birth Weight ______________lbs __________oz

Breast Fed _________ Bottle Fed? ___________

Were there frequent formula changes or special formula needed?___________________________

## ALLERGIES

Describe the reactions, the times they occurred and the actions which seemed to trigger the reactions

______________________________________________________________________________________

______________________________________________________________________________________

Drugs_________________________________________________________________________________

Insects_______________________________________________________________________________

## MEDICAL HISTORY

Are immunizations current Yes No Any adverse reactions? Yes No
Any surgery for Ears Nose Sinus Adenoids Tonsils

Ever seen an allergist or ENT physician? ________ If so, when____________________________
Any serious illness/hospitalizations? __________________________________________________
Briefly describe any other significant health problems _____________________________________
Ever been on allergy shots? Yes No When_________________________________________
Most recent sinus or chest X-ray ___________________________

## FAMILY HISTORY

Describe allergy symptoms in your family members (asthma, hay fever, sinus, etc)
Father ________________________________________________________________________________
Mother _______________________________________________________________________________

Brother/Sisters________________________________________________________________________

Are there any problems you wish to discuss during today's visit?

___________________________________________________________________________________
___________________________________________________________________________________
___________________________________________________________________________________

Please list all medications currently taking

__________________________________ __________________________________

__________________________________ __________________________________

__________________________________ __________________________________