DuPage Medical Group
ASTHMA & ALLERGY CENTER

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Dr. Dawn Beckman *Dr. Jacqueline Moran* *Dr. Brian Smart* *Dr. Thomas Van Osdol*

Patient History (Pediatric) **Your childs name:**

Please take a few moments to complete the following **two page** patient questionnaire. Thank you.

Primary Care Provider: ____________________ **Referred by:** ______________________________

What medical concerns would like addressed during today's visit (Chief Complaint)?

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Please list **your child's** current and past **medical problems** and any prior **surgeries**:

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Please list **your child's** current **medications** including dosages (if known). Please include any supplements, herbs, vitamins, etc.

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Immunization history: ☐ Up to date ☐ Not up to date/delayed: ______________________________

Medications allergies: ____

SOCIAL AND ENVIRONMENTAL HISTORIES:

Please help us get to know your child and his/her home environment a little better.

Personal History:	Home Environment:
Grade in School: ____________________	Live in: apt, house etc..____________________
School name: ____________________	Indoor animals: ☐**Yes** ☐**No** List: __________
Parents occupation(s): ____________________	__________
____________________	
Daycare/preschool: ____________________	Indoor smokers: ☐**Yes** ☐**No** List: __________
Other caretakers: ____________________	History of indoor water damage and/or indoor mold: ☐**Yes** ☐**No**
____________________	**If yes, explain:** ____________________
Tobacco/smoking history:	____________________
1. Previous use: ☐**Yes** ☐**No** Quit date: __________	
2. Current use: ☐**Yes** ☐**No** If "yes," are you interested in quitting? ☐**Yes** ☐**No**	Does *your child* use "dust mite covers" for bedding: ☐**Yes** ☐**No**
3. Packs per day/years: __________	Heating and cooling (central or window AC, gas or electric heat, fireplace etc.): ____________________
	____________________
Hobbies/Interests:	Flooring (carpet, laminate, tile, wood, etc.): __________
____________________	____________________

(PLEASE TURN PAGE OVER)

FAMILY MEDICAL HISTORY:

Do immediate family members have any of the conditions listed below (do not include your child)?

Condition:	**Family history:**	**Who (i.e. mother, father, siblings, etc):**
Allergies	☐**Yes** ☐**No**	
Sinus problems	☐**Yes** ☐**No**	
Asthma	☐**Yes** ☐**No**	
Other lung disease	☐**Yes** ☐**No**	
Eczema	☐**Yes** ☐**No**	
Thyroid problems	☐**Yes** ☐**No**	
Autoimmune disease	☐**Yes** ☐**No**	
Immune deficiency	☐**Yes** ☐**No**	
Migraines	☐**Yes** ☐**No**	
Other	**Explain:**	

REVIEW of SYSTEMS:

Please **check Yes or No** to indicate if your child ***currently*** has any problems in one or more of the following areas. If yes, please circle and/or briefly explain the problem.

Organ system:	**Yes or No**	**If yes, please circle all that apply:**
General health:	☐**Yes** ☐**No**	Recurrent fever, chills, sweats, growth delay, speech problems, developmental delay, unexplained weight loss, weight gain, excessive fatigue, sleep problems
Eyes:	☐**Yes** ☐**No**	Blurred vision, eye pain, eye discharge, redness, watering, matting/crusting, itching, gritty sensation, eyelid rash/swelling
Ears/nose/throat:	☐**Yes** ☐**No**	Hearing loss, earache, nasal congestion, nose bleeds, abnormal taste/smell, nasal drip, post nasal drip, allergies, dry mouth, sores in mouth, sore throat, hoarseness, throat clearing, bad breath
Cardiovascular:	☐**Yes** ☐**No**	Irregular heart beats, hypertension, heart problems,
Respiratory:	☐**Yes** ☐**No**	Asthma, bronchitis, cough, wheezing, shortness of breath, exercise difficulties
Gastrointestinal:	☐**Yes** ☐**No**	Reflux/heartburn, difficulty swallowing, nausea, vomiting, diarrhea, constipation, ulcers
Genitourinary:	☐**Yes** ☐**No**	Painful urination, frequent urination
Musculoskeletal:	☐**Yes** ☐**No**	Arthritis, joint pain, muscle pain, cramps, joint stiffness, joint swelling
Skin:	☐**Yes** ☐**No**	Dryness, rashes, itching, redness, swelling, change in moles
Neurology:	☐**Yes** ☐**No**	Headache, numbness/tingling, weakness, dizziness, lightheadedness
Psychiatry:	☐**Yes** ☐**No**	Anxiety, depression, ADD, ADHD
Endocrine:	☐**Yes** ☐**No**	Excessive thirst, cold intolerance, diabetes
Hematology:	☐**Yes** ☐**No**	Anemia, bleeding problems, enlarged lymph nodes

Physician Notes: ____

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☐ I have reviewed the information above.

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Physician Signature Date