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**A Center For Health and Hope**  
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\*\*\*Perfume, aftershave, hair spray, fabric softener or tobacco odor are not allowed in our office\*\*\*

Please tell us in advance if something should not be discussed in front of your child.

Please provide a written, detailed chronological summary of your child's symptoms, medicines, physicians or other pertinent information.

All relevant test results must be returned with this packet.

**NO APPOINTMENT CAN BE MADE FOR ANY PATIENT  
UNTIL ALL PERTINENT INFORMATION IS RECEIVED IN THIS OFFICE.**

Has patient ever had or been exposed to hepatitis? If so, please attach detailed lab report.

What is the major reason for this visit? \_\_\_\_\_

Check, fill-in, encircle, yes-no (answer all questions please).

**PLEASE CALL ONE WEEK AFTER RETURNING THIS FORM  
REGARDING A POSSIBLE APPOINTMENT DATE.**

<b>Date</b>	Treatment given from	to
<b>Child's Name</b>	Did it help?	
<b>Address</b>	Results of tests?	
<b>City</b>	Were blood allergy RAST tests done?	
<b>State</b>		
<b>Zip Code</b>		
<b>Phone Number</b>	<b>WE NEED ALL RECORDS &amp; EXACT SKIN TEST RESULTS</b>	
<b>Email</b>	<b>FAMILY HISTORY</b>	<i>Adopted</i> Yes___ No___
<b>Birth date</b>	<i>Has or had</i>	<i>Diagnosed by</i>
<b>Exact age</b> yrs	<i>Allergy</i>	<i>physician</i>
<b>Patient's doctor</b>	Yes/No	Yes/No
<b>Address</b>		Yes/No
<b>City</b>	<i>Child</i>	
<b>State</b>	<i>Father</i>	
<b>Zip</b>	<i>Mother</i>	
<b>Referred by:</b>	<i>Brothers</i>	
<b>PREVIOUS ALLERGY TESTS</b>	<i>Sisters</i>	
When?	<i>Grandparents</i>	
By Whom:		
Needle or scratch tests?		

Date

Was cow's milk a problem?

**ALLERGY HISTORY**

Does your child want...(encircle)  
liquids, chewable pills, tablets?  
tablets and capsules?

**FETAL HISTORY**

Did child in uterus:  
Kick: sl mod too much  
Hiccup: sl mod too much  
Did fetus hurt you?

What did mom eat in excess?  
Any excess dairy?

**INFANT HISTORY**

Birth weight: At one year:  
Present weight: Sat at:  
Walked at: Rock crib:  
Bang head: Sleep well:  
Said "mama, dada" at:  
Activity level: down up normal?  
Constipated? Diarrhea? Normal?  
Excess drooling? Smiled at age:  
Vomiting? Excess spitting up?  
Colic from: to:  
Was baby cuddly? Excess perspiration:  
Delivery OK? Explain:  
Baby leave hospital with mom?  
Thrush? Excess diaper rash?  
Did you breast feed your child?  
How long?  
Describe your baby:

Name of milk	Months on it	Reason for change
1st formula		
2nd formula		
3rd formula		
4th formula		

**NOSE PROBLEMS** began at age  
sl mod severe

When?  
Which warm months?  
Which cold months?  
All year?  
Stuffy nose?  
Watery runny nose?  
Sneeze several times in a row?  
Rub nose upward?  
Wiggle nose?  
Pick nose?  
Clear throat often?  
Lots of colds, but not sick?  
green, yellow, gray mucus?  
how often per week?  
how often per month?  
Nosebleeds?  
Mucus in throat?  
Clucking throat sounds?  
Nose polyps?  
Sinus pain?  
How often do nose problems occur?  
Can your child smell odors?  
Does your child mouth-breathe?  
Medicines of nose? Dose  
Dose  
Any problems with medications?

**EYE PROBLEMS** began at age  
sl mod severe

Itchy eyes?  
Red eyes?  
Watery eyes?  
Burning?  
Pain? Where?

Puffy eyes?

**EYE PROBLEMS cont.**

Bags under eyes?

Wrinkles under eyes?

Dark eye circles?

How often do eye problems occur?

Which months do eye problems occur?

Eyes checked for glasses?                      When?

Medicine for eyes?

**YEAST PROBLEMS**                      Yes      No

Xs antibiotics in past?

Red ring around anus?

White coated tongue?

Xs genital touching?

Smelly hair?

Smelly feet?

Bloated abdomen?

Skin rash?

**CHEST PROBLEMS** began at age

sl      mod      severe

Wheeze or asthma?

with infection?

other times?

Cough/wheeze (which)?

with laughter?

with exercise?

with cold air?

with cold drinks?

at night?

when it is damp outside?

Tight chest?

How often does cough occur?

How often does wheeze occur?

Medications used                      Dose

Dose

Ever have bad choking spell?

Any chest pain?

Ever need adrenalin?

Lips or nails turn blue with attacks?

Ever on steroids? (cortisone?)

Dates:                      Amount

Date last chest X-ray:                      Result?

Date last TB test:                      Result?

Hospitalized with asthma?

When:                      I NEED RECORDS

Encircle months chest problems occur: J=Jan, etc.

Last year:      J F M A M J J A S O N D

This year:      J F M A M J J A S O N D

Do you use Peak Flow Meter to check breathing?

**EAR PROBLEMS** began at age

A problem from                      to

sl      mod      severe

Recurrent ear fluid?

On and off hearing poorly?

Daily hearing trouble?

Do ears pop?

Earaches?

Have ear tubes?                      When?

Ever have hearing test or audiogram?

Tonsils removed?                      When?

Adenoids removed?When?

Does child speak normally?

**OTHER PROBLEMS**

Does your child have:

Autism?                      Autistic-like?

Cerebral Palsy?

Tourette's Syndrome?

Sensory, motor or perceptual pervasive  
earning disability?

Attention Deficit Disorder?

Attention Deficit Hyperactivity Disorder?

An undiagnosed neurological problem?

Is your child emotionally disturbed?

Are YOU afraid of your child?

**SKIN PROBLEMS** began at age

Sl Mod Severe

Eczema or atopic dermatitis?  
 Itchy rash arms/leg creases?  
 Itchy rash on body?  
 Cracked toe/finger tips?  
 Hives or welts?  
 Itchy skin—no rash?  
 Easy bruising?  
 Tender sore skin?  
 White fingernail specks?  
 Cold hands and feet?  
 Swollen hands/face/feet?  
 Canker sores?  
 Swelling face/lips/body?  
 Soreness edge of lips?  
 Excessive perspiration?  
 Stretch marks on skin?  
 How often do skin problems occur?

**INTESTINAL PROBLEMS** began at age

sl mod severe

Bellyaches?  
 Nausea?  
 Excess belly gas?  
 Bloating belly?  
 Belching?  
 Diarrhea?  
 Constipation? BMs per week  
 BMs on underwear?  
 Spot or smudge?  
 Itchy rectal area?  
 Bad breath?  
 Excess drooling?  
 Poor appetite?  
 Poor weight gain?

How often do these problems occur?

Unusual sudden weight gains?

Vomiting? How often?

**GYN PROBLEMS**

Age onset menses?

Menstrual problems?

Cramps Bleeding Long Periods

Depression Headache Fatigue

Irritable Vaginal itch

Vaginal discharge

Color of discharge

Other

**CAN CHILD YES NO**

Sit through a TV program?

Sit through a story?

Sit through a meal?

Any stinging insect problems?

Which insects?

What problems?

Any pets in home?

What type?

Pets cause:

**NERVOUS SYSTEM PROBLEMS** began at age

age began sl mod severe

Constant wiggling, moving?

Irritable?

Hyperactive, restless?

Clumsy?

Listless, tired?

Hostile, argumentative?

Cry easily?

Unhappy or depressed?

Behavior problems?

Seizures?

Stutter?

Talk too much?  
 Temper tantrums: how often      how long  
 Nightmares x/weekly?  
 Awaken at 3-4am?  
 Sleepy after eating?  
 Red ear lobes?  
 Red cheeks?  
 Red nose?  
 Glassy, glazed eyes?  
 Wiggly legs?  
 Hit? Bite? Spit? Kick?  
 Undresses?  
 Hours sleep? 24 hrs?      max      min  
 Ever suicidal?  
 Ever have brain wave or EEG?  
 Head injury?  
 Brain infection?  
 Ever see neurologist?      Who?  
     When?      NEED REPORT  
 Ever on Ritalin, Cylert, etc.?  
     What?  
     When?      Did it help?  
 School grades?      IQ  
 Is child's learning up to par?  
 Tics and spasms?

#### URINARY PROBLEMS—BLADDER OR KIDNEY

Began at age  
     sl      mod      severe  
 Wet pants in daytime?  
 Wet pants at night?  
     Daily?  
     Times per week?  
     Times per month?  
 Recurrent bladder infections?  
 Up most nights to wet?  
 Pain when wetting?  
 Wets (voids) often in daytime?  
 Blood in urine?

Burns when passing urine?  
 Rush to toilet so pants aren't wet?  
 Urine problems occur only at certain times per year?  
 How often do symptoms occur?  
 Unable to urinate at times?  
 Drink little or excessive fluids (which)?  
 Is it hard for child to begin to urinate?  
 Other kidney or bladder problems (explain)?  
 Has urologist been seen?

#### MISCELLANEOUS PROBLEMS

Sl      mod      severe      age began-how often  
 Axilla  
 Hips  
 Growing pains-legs  
 Leg cramps  
 Muscle aches  
 Neck, shoulder pain  
 Backache  
 Joint aches  
 Headaches  
 Sensitive to sound  
 Sensitive to light  
 Sensitive to cold  
 Excess infections  
 Fevers/no infection  
 Low grade fever  
 Sleepy in car  
 Carsick  
 Crave seasoned foods  
 Crave salt  
 Use excess ketchup  
 Coated tongue  
 Excess thirst  
 Any chemical odor or pollution cause symptoms?  
 What causes what?

of your tap water for first appointment.

Curtains: composition

## HOME

### BEDROOM (patient's room)

Pillows: feather foam cotton urethane dacron

Mattress: cotton foam urethane other

Mattress cover: plastic cotton nylon none

Blanket: wool cotton synthetic electric

Walls: wood wallpaper paint paneling

Floor: wood rug throw rug shag low nap

nylon cotton wool synthetic odor new old

Pad is

Windows: shades venetian blinds

shutters curtains/drapes

composition

Closet: mothballs insect strips

dry cleaner bags

Stuffed animals How many?

Book cases Open shelves?

Wall decorations? Plastic Storage Bags?

### LIVING OR FAMILY ROOM (whichever used most)

Is furniture new? Old?

Couch: covering filling

Chairs: covering filling

Carpet: shag low nap wool cotton synthetic odor new old

Carpet pad: ozite rubberhair & rubber

Use rug shampoos?

## KITCHEN

Floor: wood tile linoleum

If carpet, type

Usual kitchen cleaners

Stove: gas electric

Refrigerator: gas electric store food in plastic

Water: tap well bottled water softened

distilled plastic bottle

If you live outside County, bring sample

## BATHROOM

Shower curtain: plastic cotton

Aerosol used: body cleaning

Scented toilet paper:

Scented aerosols scented soaps

Scented perfumes or powders

Molds in shower area

Use aerosols?What?

## PLEASE LIST ALL FOODS EATEN FOR 1 WEEK:

Send this list on a separate sheet of paper

Be sure to fill in below:

	Foods and Beverages	
Favorite		Hated
	1.	
	2.	
	3.	
	4.	
	5.	

**IT IS BEST TO DO PART 1 AND 2 OF THE MULTIPLE ELIMINATION DIET BEFORE YOUR APPOINTMENT. DO PART 2 EVEN IF PART 1 DOES NOT APPEAR TO HELP. PUT ENTIRE FAMILY ON DIET, IF POSSIBLE. THIS CAN SAVE YOU TIME AND MONEY.**

**PART 1 RESULTS:** same worse %better

**PART 2 RESULTS:** encircle problem foods, explain effect

Milk wheat

Chocolate egg

Dyes sugar

Corn preservatives

Was entire diet completed?

Was diet done well OK well poorly

### MISCELLANEOUS

Use insecticides Use tobacco  
 Ever fumigate Remodelling  
 Painting now Use ChemLawn  
 Home drafty Home moldy  
 Use Pin-Sol Use Lysol  
 Type of insulation: foam cellulose fiberglass  
 polyurethaneother  
 Basement ever flooded House plants  
 Odors bother your child? How?  
 Attached garage Air conditioning  
 Heating: Gas oil electric fireplace radiators  
 humidifier forced hot air baseboards registers  
 dehumidifier air cleaner  
 Air purifier:  
 Hot water heater: gas electric  
 Clothes dryer: gas electric  
 Use clothes softener  
 Types of vacuum: upright water tank central  
 system  
 Hobbies in home:  
 Age of home How long in present home?  
 Anything unusual about home?  
 Swimming pool inside outside  
 Many trees What kind