Allergy Asthma Care P.C.
Dr. Kenneth W. Blumenthal
Dr. Payal D. Patel
Matyt Adler, DNP, FNP-C
www.nwi-asthma.com

CROWN POINT
5521 W. Lincoln Hwy. Suite 100
Crown Point, IN 46307
PH (219) 756-6100
Fax (219) 756-6111

PORTAGE
3125 Willowcreek Road
Portage, IN 46368
PH (219) 762-3055
Fax (219) 364-3180

VALPARAISO
2802 Leonard Drive
Valparaiso, IN 46383
PH (219) 531-5855
Fax (219) 531-1617

ASTHMA AND ALLERGY CONSULTATION *(PEDIATRICS)*

Name:______________________________ Date:__________

Age:________ Date of Birth:__________ Referred by:______________

Current Physician/Pediatrician:______________________________

What health problems is your child having? What would you like to learn and what changes would you like to see for your child as a result of this consultation ?

Are Immunizations up-to-date? ☐ Yes ☐ No

Current Medications			Drug Allergies	Reaction
Drug	Dose	How Often?		
			Food Allergies	Reaction

Over The Counter medications, nose sprays or vitamins not mentioned above?

DIET: Regular:________ Special diet:______________________

BIRTH HISTORY: Birth Weight:______Lbs.______ oz. Length:________

Complication of Pregnancy:____

Full term:____ Yes ____ No Neonatal Complications:____________________

FAMILY MEDICAL HISTORY: *(Note: Allergy & Asthma problems)*

Mother's Age:_____ Smoker: _____ Yes _____ No / Health Status: __________

Father's Age: _____ Smoker: _____ Yes _____ No / Health Status:__________

Legal Guardian Name& Age (if not the parent:) ____________ Smoker: __ Yes __ No

Parental Marital Status (Please circle): Married - Divorced - Separated - Not married - Not married living together

Child's Siblings	Age	Health Status

Any on-going or significant past illness?______________________________

Past Surgeries	Year	Hospitalizations	Year

ER / Urgent Care Visits for what & when? ______________________________

PETS: □ Dog(s) □ Cat(s) □ Reptile(s) □ Fish □ Rodents □ Bird(s) □ Others

YOUR Child's NOSE : *(check all that pertain)*

□ Seasonal symptoms? □ Symptoms worse in the morning ? □ Snores
□ Year round symptoms? □ Mouth breather? □ Frequently sneezes
□ Nasal polyps? □ Symptoms with Pet exposure □ (other)

YOUR Child's EARS : □ Frequent ear infections □ Tubes

YOUR Child's SKIN: □ Dry skin □ Hives □ Eczema □ other ____________

Child *has HISTORY of*: □ Sinus infections □ Reflux □ Pneumonia □ Croup □ RSV □ ________

Age at onset of allergy, wheezing, or chronic cough? ______________

Number of school days missed in the past twelve months? ___________

Number of *Emergency visits* for *asthma or respiratory distress* in the past?_______

Number of episodes of asthma (*any asthma problem which causes you to modify your child's activity or take different medications*).

_______ **times per year** _______ **times per month** _______ **per week**

_______ **times per** ________________ **(season)**

Asthma or Allergy Triggers: Activities or substances that bring on symptoms.

□ Respiratory infections □ Cats □ Morning cough □ Pollens □ Molds □ Cold air
□ Pollutants □ Dogs □ Night time cough □ Perfumes □ Smoke □ Exercise
□ Other____

Do symptoms get worse at certain times of the year?

□ Spring □ Summer □ Fall □ Winter

Does the child vomit, *followed by cough*, or *have wheezy cough at night*? Y / N

Are his/her symptoms worse after feeding? Y / N

ASTHMA HISTORY

DOES YOUR child HAVE: **In the past month** *(circle that applies)*

Wheezing	No	< 2 times a week	> 2 times a week	Daily
Coughing	No	< 2 times a week	> 2 times a week	Daily
Shortness of breath	No	< 2 times a week	> 2 times a week	Daily
Rapid Breathing	No	< 2 times a week	> 2 times a week	Daily
Chest tightness	No	< 2 times a week	> 2 times a week	Daily
Chest pain	No	< 2 times a week	> 2 times a week	Daily
Throat clearing	No	< 2 times a week	> 2 times a week	Daily
Difficulty breathing in	No	< 2 times a week	> 2 times a week	Daily
Coughing at night	No	< 2 times a week	> 2 times a week	Daily
Rescue medicine use	No	< 2 times a week	> 2 times a week	Daily

Steroid use: □ NO □ This week □ This month □ Last month □ This year □ Last year

Do you use an *Aerochamber* for your child's medicine? □ **Yes** □ **No**

Do you use a *tight fitting mask* for your child's nebulizer? □ **Yes** □ **No**

Living Environment: □ House (age of house _____) □ City □ Rural □ Apartment □ Trailer

Type of Heat: □ Gas forced air □ Electric □ Wood burning stove

□ Steam □ Oil □ Humidifier Central / Room

Air Conditioning: □ None □ Central □ Room □ Dehumidifier

Bedroom: ***Bed*** □ Conventional mattress □ Waterbed

Pillow □ Polyester fill □ Foam □ Down

Flooring: □ Carpet □ Hardwood □ Linoleum □ Vinyl

Basement: □ None □ Partial □ Full □ Damp

Is there anything else you would like us to know?

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Controlling your child's asthma or allergy symptom is a PARTNERSHIP between YOU and ALLERGY ASTHMA CARE.

A child MUST be ASSISTED or SUPERVISED by an adult when taking a prescribed medication.