Speciallæge PhD
IDA NORGIL
BØRNE & ALLERGIKLINIKKEN

Information form

(Please complete and bring to the first consultation or e-mail before the consultation)

The child's name_____**Cpr no**_____

Mobile phone (both parents)_____
Email (family)_____ Mobile (adolescents > 15 years)_____

Mother's name/cpr no_____
Father's/Co-parent's name/cpr no_____
Siblings' name/cpr no_____
Has any sibling been at the clinic before? ☐ Yes ☐ No If yes, name_____

Parents cohabiting ☐ Yes ☐ No ☐ Single parent
Custody ☐ Shared ☐ Mother ☐ Father/Co-parent

Does the child have allergies ☐ No ☐ Yes If yes, which_____

Pregnancy length_____(weeks) Birth weight_____(gram) Birth length_____(cm)

Complications during pregnancy
☐ No ☐ Yes If yes, which_____
Complications during birth ☐ No ☐ Yes ☐ Cesarean-section ☐ Vacuum extraction
☐ Other _____

How long was the child breastfed_____(months)
Has the child developed as expected? ☐ No ☐ Yes

Has the child ever been hospitalized? ☐ No ☐ Yes If yes, where, when and why_____
_____

Does the child follow the Danish vaccination program ☐ Yes ☐ No
Does the child get any medicine? ☐ No ☐ Yes If yes, which_____

Pets at home ☐ No ☐ Yes If yes, which_____
Smoking at home ☐ No ☐ Yes

Asthma, hay fever, eczema, food allergies in the family (parents, siblings) ☐ No ☐ Yes If yes, whom and which diseases_____

Any other diseases in the family ☐ No ☐ Yes If yes, whom and which_____
_____

Hereby, I give consent to Børne & Allergiklinikken to obtain information that is necessary for the treatment of or the evaluation of my child's disease from hospitals, specialists or other doctors

Date

Signature parent/adolescents > 15 years_____
The adolescent > 15 years does also have to sign