

Information form

(Please complete and bring to the first consultation)

The child's name _____ Date of birth/cpr no _____

Phone (Primary*) _____ (Secondary) _____

*Will receive SMS-notifications from the clinic

Email (family) _____ Mobile (adolescents > 15 years) _____

Mother's name/cpr no _____ Profession _____

Father's/Co-parent's name/cpr no _____ Profession _____

No of siblings _____ Older _____ Younger _____

Has any sibling been at the clinic before? If yes, cpr no _____

Parents cohabiting Yes No Solo parentCustody Shared Mother Father/Co-parentDoes the child have allergies No Yes If yes, which _____

Pregnancy length _____ (weeks) Birth weight _____ (gram) Birth length _____ (cm)

Complications during the pregnancy No Yes If yes, which _____Complications during birth No, normal vaginal birth Yes, cesarean section Yes, vacuum extraction Other _____How long was the child breastfed _____ (months) Has the child developed as expected No YesHas the child ever been hospitalized No Yes If yes, where, when and why _____Does the child follow the Danish vaccination program Yes NoDoes the child get any medicine No Yes If yes, which _____Pets at home No Yes If yes, which _____Smoking at home No Yes

Any family history of

Asthma No Yes If yes, who _____Hay fever* No Yes If yes, who _____Eczema No Yes If yes, who _____Food allergies No Yes If yes, who _____

(Besides pollen allergy if allergy for dust mites, animals (fur) or fungal spores)

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/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