Speciallæge PhD
IDA NORGIL
BØRNE & ALLERGIKLINIKKEN

Information form

(Please complete and bring to the first 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_____
No of siblings_____ Older_____ Younger_____
Has any sibling been at the clinic before? If yes, cpr no_____

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 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 ☐ 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

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_____

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

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