UNM | SCHOOL of MEDICINE

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Welcome to your appointment with **Pediatric Primary Immunodeficiency Center**

at University of New Mexico Children's Hospital

PEDIATRIC SPECIALTY CLINIC, ACC 3RD FLOOR,

2211 LOMAS BLVD NE, ALBUQUERQUE, NM 87106.

Please Call Office to Update Telephone Number's, Address and Insurance Information.

If you are unable to keep your appointment, we ask that you let us know with as much advanced notice as possible by calling 505-272-0331.

Please be sure to fill out **New Patient Questionnaire Form** before the appointment date. This form includes information that is important for the specialist to know in order to provide your child with the best care possible. **PLEASE COMPLETE THIS FORM BEFORE THE APPOINTMENT AND BRING IT WITH YOU.**

We look forward to your visit with us which may take 45-60 minutes. We may perform blood testing to evaluate immune system. Please bring previous immunology or allergy blood test results if appropriate. Please arrive at least 15 minutes before the appointment time to allow time to check in and complete necessary paperwork. If on the day of your appointment, you expect to be late, please call Antoinette, 505-272-0331.

We look forward to meeting and caring for you and your child!

For information about our program and Dr. Elif Dokmeci, please see back of the page.

BIOGRAPHY:

Dr. Elif Dokmeci is Head of Pediatric Allergy &Clinical Immunology Program and Director of Pediatric Immunodeficiency Center at UNM Children`s Hospital. Before joining to UNM, she served as a Clinical Director of Pediatric Allergy and Immunology Section and Director of Pediatric Primary Immunodeficiency Program at Yale University, New Haven CT.

She completed 2 fellowship programs at Yale University School of Medicine, Pediatric Pulmonology in 2006 and Allergy & Clinical Immunology in 2008.

She has a longstanding commitment to allergy and clinical immunology programs with a track record of building Pediatric Allergy and Immunodeficiency Centers in the past. She was chosen one of the leading expert Immunologist and her center obtained accreditation as Jeffrey Modell Diagnostic Center for Primary Immunodeficiency Diseases. She continues serving as medical director of New Mexico Newborn Screening Program for Severe Combined Immunodeficiency and UNM is the leading institution in the state for primary immunodeficiency diagnosis and treatment. Her clinical interests are Primary Immunodeficiency Diseases, Food Allergies, Hypersensitivity, Atopic Dermatitis, Immune Dysregulation Syndromes. Her research interests are immunodeficiency disorders, molecular and cellular mechanisms allergic disorders. Dr. Dokmeci holds several national allergy and immunology committee appointments for the American Academy of Allergy, Asthma and Immunology and Clinical Immunology Society. She actively teaches at Medical School and residency programs. She is a member of Education Committee at UNM.

PEDIATRIC PRIMARY IMMUNODEFICIENCY CENTER:

UNM Children's Hospital Pediatric Primary Immunodeficiency Center is the only complete pediatric immunology center in the state of New Mexico, providing our patients with comprehensive diagnoses and treatment.

Primary immunodeficiency is a disease category that includes more than 250 inherited disorders of the immune system. These diseases can appear at any age, although the most severe diseases appear in early childhood. Common symptoms include frequent, unusual or especially severe infections. Since these symptoms are also found in children without a primary immune deficiency, testing is typically required for diagnosis.

The first step in diagnosing a primary immunodeficiency disease is by a complete evaluation of the patient’s immune system, which is done at the Pediatric Primary Immunodeficiency Center. The initial visit to our center may include:

•Questions about a patient’s medical and family history
•An in-depth physical exam
•Blood tests
•Breathing tests
•Radiographic tests

Treatment ranges from “boosting” the immune system with vaccines to replacing it with a bone marrow cell transplant. One safe and effective treatment used is regularly giving the child immune protective replacement antibodies. This can be done at our pediatric infusion suite or in the comfort of your own home.

For more information about our Pediatric Allergy and Immunology programs (web site is currently under development), you can also visit http://hospitals.unm.edu/children/pss/allergy.shtml .

New Patient Form—Pediatric Immunodeficiency Center

- Please complete this form **now**.
- Bring it with you on the day of your appointment.
- It helps us if you read the questions carefully and answer them as fully as possible.
- If there are questions or medical terms that are not clear, please ask us when you come in.

General Information

Child`s Name: ______________________
Age: ________ Date of Birth: ____________________
Your best contact number: ____
Your Child`s Primary Care Provider: ____
Name of the doctor who recommended your visit: ____________________________________

What is the main reason for your visit? Please list the main reasons for your visit:

____
____
____
____
____
____
____

Please list any questions/concerns that you would like discussed during this visit and what you would like to accomplish with today`s visit?

____
____
____
____
____
____

Medicines

Please list all the medications your child is **taking** (including inhalers, nasal sprays, over the counter medications, prescription creams/lotions/ointments): ____________________________________

____
____
____
____

Immunizations

Are immunizations up to date? Yes ☐ No ☐ Received flu vaccine before? Yes ☐ No ☐
Any complications after vaccines: ____

Your Child's Medical and Infection History

Does your child have any of the following? Please check any that apply.

Failure to thrive	☐	Coughing up mucous (sputum)	☐	Fevers	☐
Fluid draining from ear	☐	Wheezing	☐	Shortness of breath	☐
Watery (runny) nose	☐	Stomach pain	☐	Skin rashes or eczema	☐
Postnasal drip	☐	Diarrhea (watery poop)	☐	Skin abscesses (pus under the skin)	☐
Sinus pressure	☐	Frequent infections	☐	Diaper rash	☐
Itchy, watery, red, or dry eyes	☐	Poor healing of cuts or sores	☐	Seizures	☐
Heart murmur	☐	Joint swelling	☐	Joint pain	☐

When did symptoms start? ___ years ___ months ___ weeks _____ since birth
How many infections per year or since birth? ______________________________

Infection Treatments:

Were antibiotics used? Yes ☐ No ☐ Were they oral or intravenous? Oral ☐ Intravenous ☐

How long were they used? ______________________________

How did your child respond? Poorly ☐ Partly ☐ Very well ☐

Have you been told, or do you think your child has any of the following? Please check any that apply.

Asthma	☐	Allergic Rhinitis/Hay Fever	☐	Bowel problems	☐
Eczema	☐	Sinusitis	☐	Frequent infections	☐
Atopic dermatitis	☐	Bronchitis	☐	Thyroid problems	☐
Food allergies	☐	Angioedema	☐	Heart disease	☐
Hives (Urticaria)	☐	Nasal polyps	☐	Failure to thrive	☐
Pneumonia	☐	Ear infections	☐	Acid reflux	☐
Other medical conditions: ______________________________					

Does your child have any of the following? If yes, please explain.

Family History of Immune Deficiency

History of immune deficiency in the family	Yes ☐ No ☐
Infant death due to infection in the family	Yes ☐ No ☐

If yes, please explain ____

____

Infection History

Intravenous antibiotic use required to treat infections	Yes ☐ No ☐
Hospital stay required to treat infection	Yes ☐ No ☐
Wide-spread infection that required IV antibiotics	Yes ☐ No ☐
Infection with a rare or unusual microorganism	Yes ☐ No ☐
Infection or abscess of internal organs	Yes ☐ No ☐
"Opportunistic" infection diagnosed by doctor	Yes ☐ No ☐
Infection after vaccination other than the injection site	Yes ☐ No ☐

If yes, please explain ____

____

Skin

Non-healing eczema	Yes ☐ No ☐
Non-healing skin infection or abscess	Yes ☐ No ☐
Persistent fungal skin infection	Yes ☐ No ☐
Treatment resistant skin warts	Yes ☐ No ☐

If yes, please explain ____

____

Sinus-Ear

Two or more non-allergic sinus infection within past year	Yes ☐ No ☐
Two or more middle ear infection within past year	Yes ☐ No ☐

If yes, please explain____

____

Lung

2 or more physician diagnosed or X-Ray documented pneumonia	Yes ☐ No ☐
Fungal lung infection	Yes ☐ No ☐

If yes, please explain ____

____

Heart

Congenital heart defect Yes ☐ No ☐

If yes, please explain ____

____

Mouth

Persistent cold sores	Yes ☐ No ☐
Oral ulcer (aphthae)	Yes ☐ No ☐
Oral thrush	Yes ☐ No ☐
Early loss of adult (permanent) teeth	Yes ☐ No ☐
Non-healing gum disease	Yes ☐ No ☐

If yes, please explain ____

____

Gastrointestinal

Long term (chronic) diarrhea	Yes ☐ No ☐
Unintended weight loss	Yes ☐ No ☐

If yes, please explain: ____

____

Brain

History of viral brain infection	Yes ☐ No ☐
History of meningitis	Yes ☐ No ☐

If yes, please explain: ____

____

Blood/Hematology

Abnormal blood counts (if told to you by a doctor)	Yes ☐ No ☐
Sickle cell disease	Yes ☐ No ☐

If yes, please explain ____
____

Others

History of delayed umbilical cord separation (more than 6 weeks)		Yes ☐ No ☐
Kidney disease	Yes ☐ No ☐	
Diabetes	Yes ☐ No ☐	
Rheumatologic disease	Yes ☐ No ☐	
Cancer	Yes ☐ No ☐	
Zinc deficiency	Yes ☐ No ☐	

If yes, please explain ____
____

Medicine Use

Seizure medicines (like Dilantin, Tegretol, Keppra, Depakote, Zonegran)	Yes ☐ No ☐
Rheumatologic disease medicines (like Rituxan, Immuran, Plaquenil, Sulfasalazine, Gold, Fenflofenac, Diclofenac, D-Penicillamine)	Yes ☐ No ☐
Inflammatory bowel disease medicines (like, Enabrel, Humira, Remicade)	Yes ☐ No ☐
Corticosteroid medicines (like, prednisone, prednisolone, methyl prednisone, Medrol, Solumedrol, dexamethasone, celestone	Yes ☐ No ☐
Immunosuppressive medicines (like Cyclosporine, Tacrolimus, Rapamycin)	Yes ☐ No ☐
Thyroid medicines (like Thyroxine)	Yes ☐ No ☐
Blood pressure medicines, like Captopril	Yes ☐ No ☐
Cancer medicines	Yes ☐ No ☐

Allergies

Please list your child`s allergies below:
Medication, Food, Insect stings, other

____
____
____
____
____

Please describe the reaction:
(hives, swelling, breathing problems, others)

____
____
____
____
____

Has your child had any previous allergy evaluations? Yes ☐ No ☐
If yes, when and where: ______
Skin test or blood tests results: Allergic to? ______

Your Child`s Birth History

Full term ☐ Premature ☐ Vaginal ☐ Cesarean Section ☐ (if yes why): ______
Any complications at birth: ______

Nutrition

Did your child get breast milk? Yes ☐ No ☐ ☐How many months of breast milk? ______
Name of formula/s: ______
Any feeding problems with breast milk or formula: ______
Acid reflux or eczema as a baby: ______
Any food restrictions now, including food allergies? ______

______

Has your child had any other significant illness or hospitalizations? If so, when, where, days?

______
______
______
______

Has your child had any surgeries? If so, what and when?

______
______
______

Family History

Please list any medical conditions (asthma, allergies, eczema, food allergy, cancer etc.)
Patient`s mother: ______
Patient`s father: ______
Patient`s siblings: ______
Patient`s grandparents: ______

______

Social History

Where do you live? House ☐ Apartment ☐ How old? _____ Does anyone smoke? ______
Any pets at home? Please list: ______
Is there mold or mildew? Yes ☐ No ☐ Mice? Yes ☐ No ☐ Cockroaches? Yes ☐ No ☐
What kind of heating system? Radiator or baseboard ☐ Hot air ☐
Air conditioning: None ☐ Central ☐ Separate units ☐ Humidifier or dehumidifier (Circle)
What kind of flooring: hardwood ☐ area rug☐ wall to wall ☐
Wall- to- wall carpeting in the bedrooms? Yes ☐ No ☐
Do you have allergy proof: Pillow covers? Yes ☐ No ☐ ☐Mattress covers? Yes ☐ No ☐
Do you have any air purifiers in your home? Yes ☐ No ☐ If yes (list rooms)______

______

Hobbies/sports: ______