National Jewish Health®

Science Transforming Life®

Pediatric Severe Asthma Clinic

Pre-Visit Questionnaire and Medical History

Please complete this questionnaire and bring it with you to your first appointment with the **Pediatric Severe Asthma Team at National Jewish Health**.

We know we are asking for a lot of information. This information will help our team better understand your child's medical history and other factors that will help us find answers to your child's uncontrolled asthma.

INITIAL ASTHMA VISIT

Date:____________________

Demographics

Patient name:____

Date of birth (month/day/year):__________________Age:_________years

Gender: ☐ Male ☐ Female

Address:______________________________City____________________State______Zip__________

____

Child's ethnic background *(check only one)*

- ☐ Hispanic or Latino
- ☐ Non-Hispanic or Latino
- ☐ Not sure

Child's racial background *(Please identify all that apply and check at least one.)*

- ☐ American Indian or Alaskan Native
- ☐ Asian
- ☐ Black or African American
- ☐ Caucasian
- ☐ Native Hawaiian or Other Pacific Islander

Child's primary racial identification *(Which category best describes the child, and check only one box.)*

- ☐ American Indian or Alaskan Native
- ☐ Asian or Pacific Islander
- ☐ Black or African American
- ☐ Caucasian
- ☐ Hispanic or Latino
- ☐ Other ____

Person Completing This Form

What is your relationship to the patient?

- ☐ Self
- ☐ Parent
- ☐ Legal guardian
- ☐ Other: please specify____________________

Telephone/cell:__________________Work:______________________Home: ____________________

Referring physician #1:	Referring physician #2:	Referring physician #3:
____________________	____________________	____________________
Address: ____________	Address: ____________	Address: ____________
____________________	____________________	____________________
Telephone:__________	Telephone:__________	Telephone:__________
Fax: _______________	Fax: _______________	Fax: _______________

Briefly describe the most important question or concern for your child.

____

____

At what age did your child start having respiratory issues?

_____years_____months

At what age did your child start having respiratory issues that suggested asthma?

______year________months ☐ Not sure

At what age was your child first diagnosed with asthma or "reactive airways disease?"

______year________months ☐ Not sure

Has your child ever seen an asthma or pulmonary specialist for breathing problems?

☐ Yes ☐ No

If yes, when was your child last seen by this specialist?_________________(date)

During the past year, has your child had repeated episodes of any of the following health conditions?

Asthma	☐ Yes	☐ No
Trouble breathing	☐ Yes	☐ No
Dry cough	☐ Yes	☐ No
Wheezing	☐ Yes	☐ No
Chest tightness	☐ Yes	☐ No
Bronchitis	☐ Yes	☐ No
Pneumonia	☐ Yes	☐ No
Coughing up phlegm	☐ Yes	☐ No

Please answer the following questions:

	Total # of Times	# of Times Within the Past Year	Most Recent Event	Comments
Has your child been to urgent care or the emergency room for a respiratory illness or asthma?	☐ None ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ > 4 specify ____	☐ None ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ > 4 specify ____	MM / YYYY ____/______	
Has your child been admitted to the hospital for more than 24 hours due to a respiratory illness or asthma?	☐ None ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ > 4 specify ____	☐ None ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ > 4 specify ____	MM / YYYY ____/______	
Has your child been admitted to the ICU (intensive care unit) for a respiratory illness or asthma?	☐ None ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ > 4 specify ____	☐ None ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ > 4 specify ____	MM / YYYY ____/______	

Please answer the following questions:				
	Total # of Times	# of Times Within the Past Year	Most Recent Event	Comments
Has your child been on a ventilator or intubated for a respiratory illness or asthma?	☐ None ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ > 4 specify ____	☐ None ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ > 4 specify ____	MM / YYYY ____ /______	
Has your child needed prednisone (Prelone®, Orapred®, Pediapred®) or Medrol® burst for acute asthma?	☐ None ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ > 4 specify ____	☐ None ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ > 4 specify ____	MM / YYYY ____ /______	How many days? ______ Dose: ________

In the past year, has your child missed any school days due to respiratory illness?

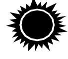
- ☐ More than a month
- ☐ More than two weeks, but not over a month
- ☐ At least five days, but not more than two weeks
- ☐ Less than five days
- ☐ None
- ☐ Not applicable/child does not attend school

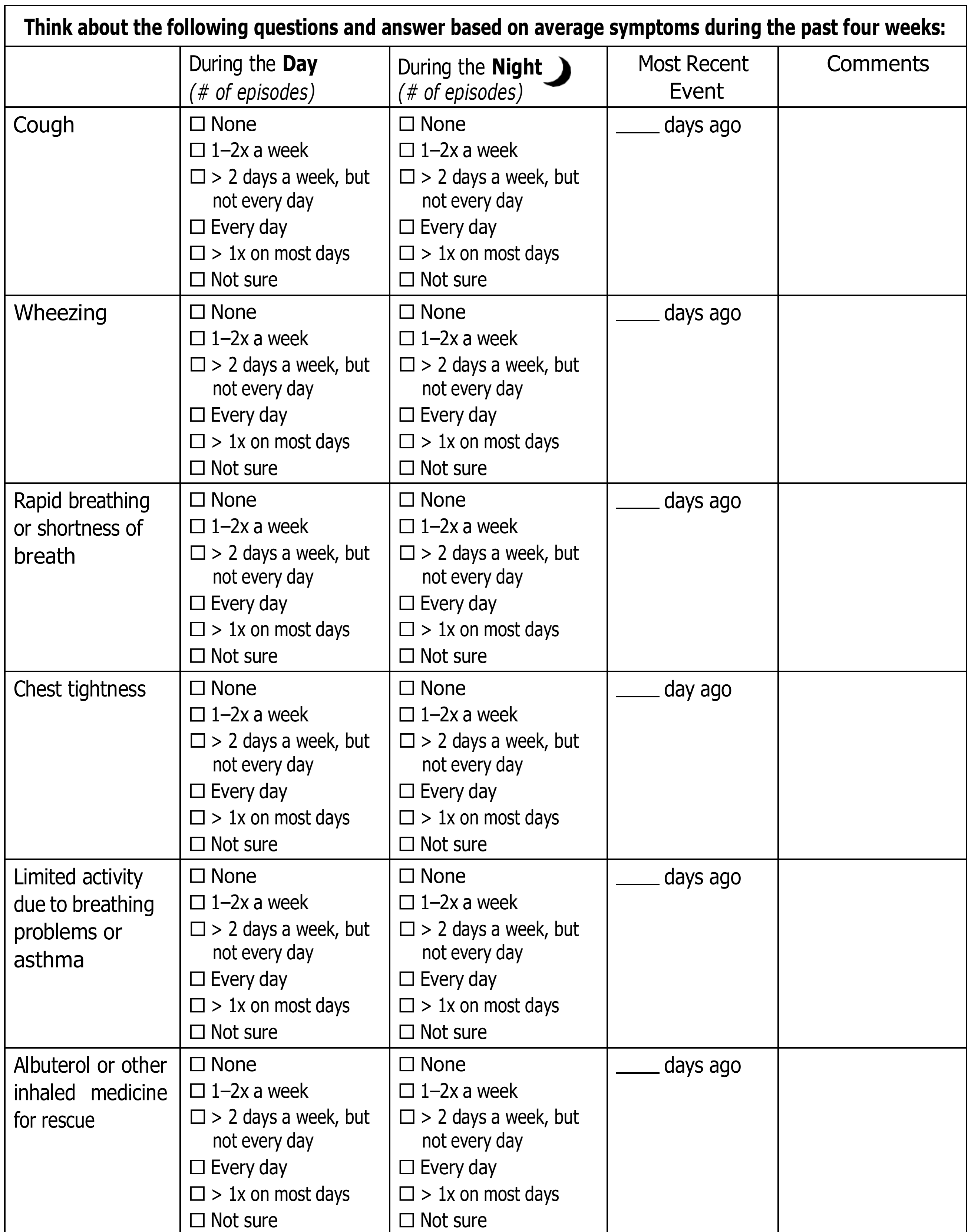
Has your child ever seen the school nurse for breathing problems?

- ☐ Yes. How many times this school year? _______________
- ☐ No
- ☐ Not applicable/child does not attend school

In the past year, have you missed any work or school days due to your child's respiratory illness?

- ☐ More than a month
- ☐ More than two weeks, but not over a month
- ☐ At least five days, but not more than two weeks
- ☐ Less than five days
- ☐ No
- ☐ Not applicable/not currently working





Think about the following questions and answer based on average symptoms during the past four weeks:				
	During the **Day** *(# of episodes)*	During the **Night** *(# of episodes)*	Most Recent Event	Comments
Cough	☐ None ☐ 1–2x a week ☐ > 2 days a week, but not every day ☐ Every day ☐ > 1x on most days ☐ Not sure	☐ None ☐ 1–2x a week ☐ > 2 days a week, but not every day ☐ Every day ☐ > 1x on most days ☐ Not sure	_____ days ago	
Wheezing	☐ None ☐ 1–2x a week ☐ > 2 days a week, but not every day ☐ Every day ☐ > 1x on most days ☐ Not sure	☐ None ☐ 1–2x a week ☐ > 2 days a week, but not every day ☐ Every day ☐ > 1x on most days ☐ Not sure	_____ days ago	
Rapid breathing or shortness of breath	☐ None ☐ 1–2x a week ☐ > 2 days a week, but not every day ☐ Every day ☐ > 1x on most days ☐ Not sure	☐ None ☐ 1–2x a week ☐ > 2 days a week, but not every day ☐ Every day ☐ > 1x on most days ☐ Not sure	_____ days ago	
Chest tightness	☐ None ☐ 1–2x a week ☐ > 2 days a week, but not every day ☐ Every day ☐ > 1x on most days ☐ Not sure	☐ None ☐ 1–2x a week ☐ > 2 days a week, but not every day ☐ Every day ☐ > 1x on most days ☐ Not sure	_____ day ago	
Limited activity due to breathing problems or asthma	☐ None ☐ 1–2x a week ☐ > 2 days a week, but not every day ☐ Every day ☐ > 1x on most days ☐ Not sure	☐ None ☐ 1–2x a week ☐ > 2 days a week, but not every day ☐ Every day ☐ > 1x on most days ☐ Not sure	_____ days ago	
Albuterol or other inhaled medicine for rescue	☐ None ☐ 1–2x a week ☐ > 2 days a week, but not every day ☐ Every day ☐ > 1x on most days ☐ Not sure	☐ None ☐ 1–2x a week ☐ > 2 days a week, but not every day ☐ Every day ☐ > 1x on most days ☐ Not sure	_____ days ago	

How well does albuterol work in decreasing symptoms?

- ☐ Albuterol (or Xopenex®) almost always helps
- ☐ Albuterol (or Xopenex®) helps most of the time
- ☐ Albuterol (or Xopenex®) helps but does not last very long
- ☐ Albuterol (or Xopenex®) does not help much at all
- ☐ My child does not usually take albuterol (or Xopenex®) for symptoms

Acute Illness

In the past week, how many days did your child have episodes of cough, chest tightness, trouble breathing or wheezing in the morning or during the day?________days

In the past week, how often has your child had episodes of cough, chest tightness, trouble breathing or wheezing at night or early in the morning?________nights

In the past week, how often has your child used a rescue medicine (albuterol, Xopenex®, or Duoneb®) to treat cough, chest tightness, trouble breathing or wheezing?

_______times Last dose: ___________

Has your child had increased episodes of coughing, chest tightness, trouble breathing or wheezing in the past 24-48 hours? ☐ Yes ☐ No ☐ Not sure

Do any of the following currently trigger your child's asthma? *(check all that apply)*

- ☐ Exercise
- ☐ Colds/upper respiratory infection
- ☐ Seasonal
- ☐ Change in weather
- ☐ Environmental change
- ☐ Pollens
- ☐ Cold air
- ☐ Irritant exposure (pollution, odors, cleaners, chemicals)
- ☐ Dust
- ☐ Tobacco smoke exposure
- ☐ Cat exposure
- ☐ Dog exposure
- ☐ Other furred animals, specify:_________________
- ☐ Feathered animals, specify:___________________
- ☐ New medication, specify:_____________________
- ☐ Aspirin or NSAID exposure
- ☐ Food(s), specify: ____________________
- ☐ Emotional factors (stress, laughing)
- ☐ Menstruation
- ☐ No known trigger
- ☐ Other, specify:_______________________________

For each season of the year, to what extent does your child usually have asthma symptoms?

Fall	**Winter**	**Spring**	**Summer**
☐ A lot	☐ A lot	☐ A lot	☐ A lot
☐ A little	☐ A little	☐ A little	☐ A little
☐ None	☐ None	☐ None	☐ None

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Exercise

In the past 12 months, has your child's asthma ever stopped him/her from taking part in sports, recess, physical education or other school activities?

☐ Yes ☐ No ☐ Don't know

In the past three months, how many days did your child's asthma/breathing problems keep him/her from taking part in sports, exercise or physical activity?__________days

Does your child engage in regular exercise or physical activity?

☐ Yes, days per week:_________ ☐ No

Please specify what activity/activities your child is involved in: ________________________________

____

____

Think about all the activities that your child did during the past month. How much was the child bothered by his/her asthma?

☐ Not bothered at all
☐ Hardly bothered at all
☐ Bothered a little
☐ Somewhat bothered
☐ Quite bothered
☐ Very bothered
☐ Extremely bothered

Does your child wheeze or cough with any type of physical activity?

☐ Every day
☐ More than once a day on most days
☐ More than two days a week, but not every day
☐ Once or twice a week
☐ Never
☐ Not sure

How often has your child used medications for exercise pre-treatment?

☐ Every day
☐ More than two days a week, but not every day
☐ Once or twice a week
☐ Never

Medication Support and Self Care

How well does your child take his/her asthma medications? (*check all that apply*)

☐ Can take medicine by him/herself
☐ Forgets to take medicine. Missed doses per week: _____________
☐ Needs help taking medicine
☐ Not using medicine now

How often do you refill your child's albuterol (vials, Proair®, Ventolin®, Proventil®, Xopenex®, Maxair®) canisters?

☐ Less than monthly
☐ Once a month
☐ Once in two-three months
☐ More than three months ago
☐ Not sure

Does your child use a spacer or a holding chamber to deliver medications that use an inhaler?
☐ Yes ☐ No

Does your child have a peak flow meter? ☐ Yes ☐ No

If yes, has your child used it in the past month? ☐ Yes ☐ No

If yes, what is your child's average peak flow reading? ______________________

What is your child's best peak flow reading? ______________________

Other Associated Conditions

Rhinitis/allergies:

Nose congestion	☐ Yes	☐ No
Stuffy nose	☐ Yes	☐ No
Runny nose	☐ Yes	☐ No
Itchy nose	☐ Yes	☐ No
Itchy eyes	☐ Yes	☐ No
Watery eyes	☐ Yes	☐ No
Puffy eyes	☐ Yes	☐ No
Can't smell/taste well	☐ Yes	☐ No
Nasal polyps	☐ Yes	☐ No

Medicines, nose sprays:

Astelin®	☐ Yes	☐ No
Flonase®/fluticasone	☐ Yes	☐ No
Nasacort®	☐ Yes	☐ No
Nasarel®	☐ Yes	☐ No
Nasonex®	☐ Yes	☐ No
Omnaris®	☐ Yes	☐ No
Patanase®	☐ Yes	☐ No
Rhinocort®	☐ Yes	☐ No
Veramyst®	☐ Yes	☐ No
Nasal saline wash	☐ Yes	☐ No

Medicines, antihistamines:

☐ Benadryl®/diphenhydramine	☐ Allegra®/fexofenadine
☐ Clarinex®/desloratadine	☐ Xyzal®/levocetirine
☐ Claritin®/loratadine	☐ Zyrtec®/cetirizine

Sinusitis?	☐ Yes	☐ No	If yes, how many times? ____________
Antibiotics since last visit:	☐ Yes	☐ No	If yes, when? ____________
Had a sinus CT (CAT) scan?	☐ Yes	☐ No	If yes, when? ____________
Ear infections?	☐ Yes	☐ No	If yes, how many times? ____________
Pneumonia?	☐ Yes	☐ No	If yes, how many times? ____________
If yes, diagnosed with chest X-ray?	☐ Yes	☐ No	If yes, date(s)? ____________
Antibiotics since last visit:	☐ Yes	☐ No	If yes, when? ____________
Had a chest CT (CAT) scan?	☐ Yes	☐ No	If yes, when? ____________

RSV/bronchiolitis? ☐ Yes ☐ No If yes, date(s)? ____________

Bronchitis or croup? ☐ Yes ☐ No If yes, date(s)? ____________

Vocal cord dysfunction? ☐ Yes ☐ No If yes, when? ____________

Trouble swallowing? ☐ Yes ☐ No If yes, when? ____________

Gastroesophageal reflux disease? ☐ Yes ☐ No If yes, when? ____________

Symptoms, specify: ____________

Current Medicines Being Used

Zantac®/ranitidine ☐ Yes ☐ No

Prilosec®/omeprazole ☐ Yes ☐ No

Prevacid®/lansoprazole ☐ Yes ☐ No

Aciphex®/rabeprazole ☐ Yes ☐ No

Protonix®/pantoprazole ☐ Yes ☐ No

Nexium®/esomeprazole ☐ Yes ☐ No

Over-the-counter antacids, specify: ____________

Sleep apnea? ☐ Yes ☐ No

Ever had a sleep study? ☐ Yes ☐ No If yes, when and where?

Overweight? ☐ Yes ☐ No

Eczema?

Has your child ever had eczema? ☐ Yes ☐ No

If yes, at what age did the child first have eczema?_______years______months

Does your child currently have eczema? ☐ Yes ☐ No

Does the patient use topical steroids for eczema? ☐ Yes ☐ No

If yes, specify: ____________

Does the patient use wet wraps for eczema? ☐ Yes ☐ No

What part(s) of the body currently are affected?____________

____

Food allergy? ☐ Yes ☐ No

If yes, specify: ____________

If yes, do you carry EpiPen®(s)? ☐ Yes ☐ No

Medication allergy? ☐ Yes ☐ No

If yes, specify: ____________

Anaphylaxis? ☐ Yes ☐ No

Date(s)/Details: ____________

____

Any other related conditions? ☐ Yes ☐ No

If yes, specify: ____________

Smoking

Does the patient smoke cigarettes? ☐ Yes ☐ No

How many cigarettes/day?________How long? ____________________

Does the patient smoke marijuana? ☐ Yes ☐ No

How many/day?_______How long? ____________________

Second-hand smoke exposure? ☐ Yes ☐ No

How many smokers in the household? ____________________

Which of the asthma medications listed below does your child currently take?
Be sure to check all boxes that apply.

Medication Name	Dosage or Strength	Number of Puffs Each Time	How Often	Approximate Date of Last Refill
Inhaled Steroids				
☐ Azmacort®	☐ 100 mcg		☐ 1x/day ☐ 2x/day ☐ 3x/day ☐ other______☐ as needed	
☐ Asmanex®	☐ 110 mcg ☐ 220 mcg		☐ 1x/day ☐ 2x/day ☐ 3x/day ☐ other______☐ as needed	
☐ Alvesco	☐ 80 mcg ☐ 160 mcg		☐ 1x/day ☐ 2x/day ☐ 3x/day ☐ other______☐ as needed	
☐ Flovent® HFA	☐ 44 mcg ☐ 110 mcg ☐ 220 mcg		☐ 1x/day ☐ 2x/day ☐ 3x/day ☐ other______☐ as needed	
☐ Flovent® DISKUS	☐ 50 mcg ☐ 100 mcg ☐ 200 mcg		☐ 1x/day ☐ 2x/day ☐ 3x/day ☐ other______☐ as needed	
☐ Pulmicort® Flexhaler	☐ 90 mcg ☐ 180 mcg		☐ 1x/day ☐ 2x/day ☐ 3x/day ☐ other______☐ as needed	
☐ Pulmicort®/budesonide respules	☐ 0.25 mg ☐ 0.5 mg ☐ 1 mg	N/A	☐ 1x/day ☐ 2x/day ☐ 3x/day ☐ other______☐ as needed	
☐ Qvar® HFA	☐ 40 mcg ☐ 80 mcg		☐ 1x/day ☐ 2x/day ☐ 3x/day ☐ other______☐ as needed	
Combination Medications (Inhaled Steroid and Long-Acting Bronchodilator)				
☐ Advair® HFA	☐ 45/21 ☐ 115/21 ☐ 230/21		☐ daily ☐ 2x/day ☐ 3x/day ☐ other______☐ as needed	
☐ Advair® DISKUS	☐ 100/50 ☐ 250/50 ☐ 500/50		☐ daily ☐ 2x/day ☐ 3x/day ☐ other______☐ as needed	
☐ Symbicort® HFA	☐ 80/4.5 ☐ 160/4.5		☐ daily ☐ 2x/day ☐ 3x/day ☐ other______☐ as needed	
☐ Dulera® HFA	☐ 100/5 ☐ 200/5		☐ daily ☐ 2x/day ☐ 3x/day ☐ other______☐ as needed	

Long-Acting Bronchodilators				
☐ Foradil® Aerolizer	12 mcg		☐ daily ☐ 2x/day ☐ 3x/day ☐ other______☐ as needed	
☐ Serevent® DISKUS	50 mcg		☐ daily ☐ 2x/day ☐ 3x/day ☐ other______☐ as needed	
☐ Spiriva®	18 mcg		☐ daily ☐ 2x/day ☐ 3x/day ☐ other______☐ as needed	
Fast-Acting Bronchodilators				
☐ Albuterol nebulizer		N/A	**Before exercise** (pretreat) ☐ 1-2 days/week ☐ 3-6 days/week ☐ everyday **Rescue use only** (as needed) ☐ 1-2 days/week ☐ 3-6 days/week ☐ everyday ☐ often more than 2x/day	
☐ Xopenex®/levalbuterol nebulizer	☐ 0.63 mg/3 mL ☐ 1.25 mg/3 mL ☐ 2.5 mg/3 mL	N/A	**Before exercise** (pretreat) ☐ 1-2 days/week ☐ 3-6 days/week ☐ everyday **Rescue use only** (as needed) ☐ 1-2 days/week ☐ 3-6 days/week ☐ everyday ☐ often more than 2x/day	
☐ Ventolin®/albuterol (blue inhaler)	108 mcg/spray		**Before exercise** (pretreat) ☐ 1-2 days/week ☐ 3-6 days/week ☐ everyday **Rescue use only** (as needed) ☐ 1-2 days/week ☐ 3-6 days/week ☐ everyday ☐ often more than 2x/day	
☐ Proair®/albuterol (red inhaler)	90 mcg/spray		**Before exercise** (pretreat) ☐ 1-2 days/week ☐ 3-6 days/week ☐ everyday **Rescue use only** (as needed) ☐ 1-2 days/week ☐ 3-6 days/week ☐ everyday ☐ often more than 2x/day	
☐ Proventil®/albuterol (yellow inhaler)	90 mcg/spray		**Before exercise** (pretreat) ☐ 1-2 days/week ☐ 3-6 days/week ☐ everyday **Rescue use only** (as needed) ☐ 1-2 days/week ☐ 3-6 days/week ☐ everyday ☐ often more than 2x/day	
☐ Maxair® Autohaler/albuterol	0.2 mg/spray		**Before exercise** (pretreat) ☐ 1-2 days/week ☐ 3-6 days/week ☐ everyday **Rescue use only** (as needed) ☐ 1-2 days/week ☐ 3-6 days/week ☐ everyday ☐ often more than 2x/day	

☐ Xopenex® HFA/levalbuterol	☐ 45 mcg/spray		**Before exercise** (pretreat) ☐ 1-2 days/week ☐ 3-6 days/week ☐ everyday **Rescue use only** (as needed) ☐ 1-2 days/week ☐ 3-6 days/week ☐ everyday ☐ often more than 2x/day	
☐ Combivent® Respimat	☐ 20 mcg/100 mcg		**Before exercise** (pretreat) ☐ 1-2 days/week ☐ 3-6 days/week ☐ everyday **Rescue use only** (as needed) ☐ 1-2 days/week ☐ 3-6 days/week ☐ everyday ☐ often more than 2x/day	

Other Medications

Medication Name	Dosage or Strength	Number of Pills Each Time	How Often	Approximate Date of Last Refill
Leukotriene-Modifying Agents				
☐ Singulair®/montelukast	☐ 4 mg ☐ 5 mg ☐ 10 mg		☐ daily ☐ 2x/day ☐ 3x/day ☐ other______☐ as needed	
☐ Accolate®/zafirlukast	☐ 10 mg ☐ 20 mg		☐ daily ☐ 2x/day ☐ 3x/day ☐ other______☐ as needed	
☐ Zyflo®/zileuton	☐ 600 mg		☐ daily ☐ 2x/day ☐ 3x/day ☐ other______☐ as needed	
Oral Steroids				
☐ Prednisone tablet	☐________mg		☐ daily ☐ 2x/day ☐ 3x/day ☐ other______☐ as needed	
☐ Orapred®, Prelone®, Pediapred®, prednisolone syrup	☐________mg		☐ daily ☐ 2x/day ☐ 3x/day ☐ other______☐ as needed	
☐ Medrol®/methylprednisolone tablets	☐________mg		☐ daily ☐ 2x/day ☐ 3x/day ☐ other______☐ as needed	
☐ Decadron®/dexamethasone tablets	☐________mg		☐ daily ☐ 2x/day ☐ 3x/day ☐ other______☐ as needed	
Other Treatment				
☐ Theophylline	☐________mg		☐ daily ☐ 2x/day ☐ 3x/day ☐ other______☐ as needed	
☐ Xolair®		NA	☐ daily ☐ 2x/day ☐ 3x/day ☐ other______☐ as needed	
☐ Allergy shots		NA	☐ daily ☐ 2x/day ☐ 3x/day ☐ other______☐ as needed	
☐ Calcium	☐________mg		☐ daily ☐ 2x/day ☐ 3x/day ☐ other______☐ as needed	
☐ Vitamin D	☐________IU		☐ daily ☐ 2x/day ☐ 3x/day ☐ other______☐ as needed	
☐ Others				

_________ Initials

HEALTH PROBLEMS (REVIEW OF SYSTEMS)

General Symptoms

☐ Fatigue
☐ Fever/chills
☐ Trouble sleeping
☐ Loss of appetite
☐ Other (specify): ____________________

Eyes
☐ Blurred vision ☐ Burning ☐ Cataracts
☐ Frequent blinking ☐ Far-sighted ☐ Itching ☐ Lazy eye
☐ Near-sighted ☐ Redness ☐ Swelling ☐ Watery eyes
☐ Wears glasses ☐ Other (specify): ____________________
Date of last eye examination:________/_______(month / year)

ENT
☐ Change in sense of smell ☐ Dry mouth ☐ Ear pain
☐ Enlarged lymph nodes ☐ Hearing loss ☐ Hoarseness/change in voice
☐ Itchy eyes ☐ Itchy nose ☐ Mouth breathing
☐ Mouth sores ☐ Nasal congestion ☐ Nasal drainage
☐ Nasal polyps ☐ Nosebleeds ☐ Post-nasal drip
☐ Sinus congestion ☐ Sneezing ☐ Snoring
☐ Sore throat ☐ Stridor ☐ Throat tightness
☐ Other (specify): ____________________

Speech
☐ Delay/Impediment ☐ Slurred ☐ Stuttering
☐ Other (specify): ____________________

Heart
☐ Chest pain ☐ Dizziness ☐ Murmurs ☐ Fainting spells
☐ Irregular heartbeat ☐ Palpitations ☐ Other (specify): ____________________

Lungs
☐ Chest tightness ☐ Cough – nonproductive/dry ☐ Cough – productive (phlegm)
☐ Cough at night ☐ Coughing up blood ☐ Frequent bronchitis/chest colds
☐ Wheezing ☐ Shortness of breath – day ☐ Shortness of breath – night
☐ Shortness of breath – exercise or vigorous play ☐ Low oxygen levels
☐ Other (specify): ____________________

GI
☐ Abdominal pain/stomach ache ☐ Bloody stool ☐ Bloating
☐ Burping ☐ Choking on food/drink ☐ Constipation ____________
☐ Diarrhea ☐ Gassiness ☐ Heartburn/acid taste in mouth
☐ Indigestion ☐ Nausea ☐ Vomiting
☐ Regurgitation/spitting up ☐ Trouble swallowing
☐ Other (specify): ____________________

Initials

Feeding and Nutrition:

Do you have any concerns about your child's weight or height?

☐ Weight loss ☐ Poor weight gain ☐ Too short

☐ Too thin ☐ Too fat

Does the child have:

Difficulty eating? ☐ Yes ☐ No

Loss of appetite? ☐ Yes ☐ No

Food avoidance? ☐ Yes ☐ No

If yes, does the child avoid or refuse particular foods?

☐ Milk ☐ Egg ☐ Wheat ☐ Soy ☐ Peanut ☐ Tree nuts

☐ Fish ☐ Shellfish ☐ Others:______________________________

Does the child avoid certain textures or types of foods?

☐ Soft/mushy texture ☐ Crunchy texture ☐ Bolus foods (e.g. meats/breads)

☐ Spicy foods ☐ Others: ______________________________

Does the child cough or choke/gag when eating or drinking?

Liquids ☐ Yes ☐ No

Solids ☐ Yes ☐ No

Others:______________________________ ☐ Yes ☐ No

Genitourinary ☐ Bedwetting ☐ Wetting pants ☐ Encoporesis (soiling pants)

☐ Frequent urination ☐ Painful urination ☐ Menstruation: Onset:_____years

☐ Other (specify): ______________________________

Muscles and Bones

☐ Fractures ☐ Back pain ☐ Joint pain

☐ Muscle pain ☐ Muscle weakness

☐ Other (specify): ______________________________

Neurologic ☐ Concentration problems ☐ Difficulty walking ☐ Headaches

☐ Numbness ☐ Tremors ☐ Seizures ☐ Weakness

☐ Other (specify): ______________________________

Skin ☐ Easy bruising ☐ Eczema ☐ Hair loss ☐ Hives/welts

☐ Infections ☐ Itching ☐ Lumps ☐ Rashes

☐ Other (specify): ______________________________

Blood Diseases

☐ Anemia ☐ Easy bruising ☐ Bleeding tendency – hemophilia

☐ Sickle cell anemia ☐ Other (specify): ______________________________

Sleep ☐ Excessive daytime sleepiness ☐ Insomnia ☐ Morning headache

☐ Snoring ☐ Nonrestorative sleep (not rested after)

☐ Restless sleep (frequent change in position)

☐ Stopping breathing (apnea) ☐ Other (specify): ______________________________

Psychological ☐ Anxious/worried ☐ Depressed/tearful ☐ Developmental delay

☐ Hyperactive ☐ Mood swings ☐ Panic attacks ☐ Stressed

☐ Trouble at school ☐ Other (specify):______________________________

PAST MEDICAL HISTORY

Length of mother's pregnancy with patient:
- ☐ Full-term (38-42 weeks)
- ☐ Early (# of weeks) _____
- ☐ Late (# of weeks) _____

Birth Weight:________lbs_________oz

Type of Delivery: ☐ Vaginal, normal ☐ Vaginal, breech
☐ Planned C-section ☐ Emergency C-section

Were there problems during the pregnancy?
☐ No ☐ Yes (specify):______________________________

Were there problems during labor or delivery?
☐ No ☐ Yes (specify):______________________________

Did your child have breathing problems at birth?
☐ No ☐ Yes (specify):______________________________

Was your child breast fed? ☐ No ☐ Yes (specify # of months) _____

Was your child formula fed?
☐ No ☐ Yes (specify formula type): ______________________________
☐ Cow's milk ☐ Soy milk ☐ Other (specify):______________________________

Did your child have colic? ☐ Yes ☐ No

What was your child's growth pattern?
- ☐ Normal
- ☐ Rapid
- ☐ Slow

What was your child's development rate (sitting, crawling, walking, talking)?
- ☐ Normal
- ☐ Delayed

Has your child been hospitalized? ☐ Yes ☐ No

If yes, how many times has your child been hospitalized: _______

MM DD YYYY

___/___/_____Reason: ______________________________

___/___/_____Reason: ______________________________

___/___/_____Reason: ______________________________

___/___/_____Reason: ______________________________

___/___/_____Reason: ______________________________

PAST SURGICAL HISTORY

Has your child had any surgeries? ☐ Yes ☐ No

If yes, complete the following:

- ☐ Ear tubes: Year ___________
- ☐ Tonsillectomy: Year ___________
- ☐ Adenoidectomy: Year ___________
- ☐ Sinus surgery: Year ___________
- ☐ Reflux surgery: Year ___________
- ☐ Appendectomy: Year ___________
- ☐ Hernia repair: Year ___________
- ☐ Other:___________ Year___________

IMMUNIZATION HISTORY

Are your child's immunizations up to date?

- ☐ Yes
- ☐ No (explain): ____

Did your child receive a flu shot this year? ☐ Yes ☐ No

FAMILY MEDICAL HISTORY

Child's Father: Age_____years

Does he have any of the following conditions? (mark all that apply)

☐ No allergies ☐ Allergic to animals ☐ Asthma
☐ Food allergies ☐ Hay fever ☐ Insect sting allergy
☐ Latex allergy ☐ Medication allergies ☐ Eczema
☐ Other, specify: ____________________

Child's Mother: Age_____years

Does she have any of the following conditions? (mark all that apply)

☐ No allergies ☐ Allergic to animals ☐ Asthma
☐ Food allergies ☐ Hay fever ☐ Insect sting allergy
☐ Latex allergy ☐ Medication allergies ☐ Eczema
☐ Other, specify: ____________________

Child's Brothers/Sisters? Number: ____

Sibling 1: Age_____years ☐ Female ☐ Male

Does he/she have any of the following conditions? (mark all that apply)

☐ No allergies ☐ Allergic to animals ☐ Asthma
☐ Food allergies ☐ Hay fever ☐ Insect sting allergy
☐ Latex allergy ☐ Medication allergies ☐ Eczema
☐ Other, specify: ____________________

Sibling 2: Age_____years ☐ Female ☐ Male

Does he/she have any of the following conditions? (mark all that apply)

☐ No allergies ☐ Allergic to animals ☐ Asthma
☐ Food allergies ☐ Hay fever ☐ Insect sting allergy
☐ Latex allergy ☐ Medication allergies ☐ Eczema
☐ Other, specify: ____________________

Sibling 3: Age_____years ☐ Female ☐ Male

Does he/she have any of the following conditions? (mark all that apply)

☐ No allergies ☐ Allergic to animals ☐ Asthma
☐ Food allergies ☐ Hay fever ☐ Insect sting allergy
☐ Latex allergy ☐ Medication allergies ☐ Eczema
☐ Other, specify: ____________________

Does any family member have cystic fibrosis? ☐ Yes ☐ No

Does any family member have any other type of lung disease? ☐ Yes ☐ No

Specify: ____________________

ENVIRONMENTAL HISTORY

Child primarily lives with:

- ☐ Both parents
- ☐ Mother
- ☐ Father
- ☐ Alternates between ______________________________
- ☐ Other (specify): ______________________________

What type of dwelling do you live in?

- ☐ Apartment/condo
- ☐ House
- ☐ Townhouse
- ☐ Mobile home
- ☐ Other (specify): ______________________________

What year was your current residence built?__________or age in years:________years

How long have you lived in your current residence?_____Years_____Months

Is there a basement? ☐ No ☐ Yes (mark all that apply):

☐ Finished ☐ Unfinished ☐ Dry ☐ Damp

What type of heating system does the residence have? (mark all that apply)

☐ Electric baseboard heat ☐ Fireplace ☐ Forced hot air (gas)

☐ Hot water radiator or furnace ☐ Space heater ☐ Wood-burning stove

☐ Other (specify): ______________________________

What type of cooling system does the residence have? (mark all that apply)

☐ Central air conditioning ☐ Swamp cooler

☐ Window (room) air conditioning ☐ None

What type of air filtration unit does the residence have? (mark all that apply)

☐ Central air filter ☐ Portable air filter ☐ None ☐ Unknown

What type of humidifier is in the residence? (mark all that apply)

☐ Humidifier on central system ☐ Portable humidifier ☐ None ☐ Unknown

Has there been any water damage in your home (such as flooding or leaking pipes, toilet or roof), including the basement? ☐ Yes ☐ No

Has there been any mold or moldy smell, on any surfaces, inside your house in the past 12 months?

☐ No ☐ Yes

Do you ever see cockroaches in your house? ☐ Yes ☐ No

Do you ever see rodents (mice, rats) or rodent droppings in your house? ☐ Yes ☐ No

Are any of the following located on your property or next to your property?

Barns	☐ Yes	☐ No
Hay	☐ Yes	☐ No
Woodsheds	☐ Yes	☐ No
Firewood	☐ Yes	☐ No
Chicken coops	☐ Yes	☐ No
Corral	☐ Yes	☐ No

What type of window coverings are there in the residence? (mark all that apply)

☐ Curtains ☐ Venetian blinds ☐ Other (specify): ______________________________

How many smokers live in the residence? _____

☐ Child (patient) ☐ Father ☐ Mother ☐ Sibling(s)

☐ Other relatives ☐ Other visitors

Do you have pets/animals? (mark all that apply)

☐ Bird(s)/number: ____ ☐ Indoor ☐ Outdoor ☐ Both Indoor/Outdoor ☐ In bedroom

☐ Cat(s)/number: ____ ☐ Indoor ☐ Outdoor ☐ Both Indoor/Outdoor ☐ In bedroom

☐ Dog(s)/number: ____ ☐ Indoor ☐ Outdoor ☐ Both Indoor/Outdoor ☐ In bedroom

☐ Other pet(s)/number: ______

Specify:____________ ☐ Indoor ☐ Outdoor ☐ Both Indoor/Outdoor ☐ In bedroom

Specify:____________ ☐ Indoor ☐ Outdoor ☐ Both Indoor/Outdoor ☐ In bedroom

What type of furnishings does your child's bedroom have? (mark all that apply)

Flooring: ☐ Carpet ☐ Hardwood ☐ Tile

☐ Other (specify): ______________________________

Pillow(s): ☐ Feather ☐ Foam ☐ Polyfill

Other (specify): ______________________________

How old are the pillows?______years/months

Mattress: ☐ Regular ☐ Waterbed ☐ Other (specify): ______________________

How old is the mattress?__________years/months

How many stuffed animals are in the bedroom? ______________________

SOCIAL HISTORY

What grade is your child in?__________________ ☐ Not applicable

Is your child home-schooled? ☐ Yes ☐ No

Does your child attend daycare? ☐ Yes ☐ No

How many hours per week?_______hours

How many children are in his/her daycare? _____

Does your child have problems in school with learning or with teachers? ☐ Yes ☐ No

Is your child in special education classes? ☐ Yes ☐ No

(If yes, please bring individualized education plan)

Has your child had psychological testing? ☐ Yes ☐ No

(If yes, please bring report)

What are your child's hobbies/interests?

____

Does your child have any of the following difficulties or problems?

Making or keeping friends ☐ Yes ☐ No

Paying attention ☐ Yes ☐ No

Overly active ☐ Yes ☐ No

Frequent worrying ☐ Yes ☐ No

Frequent stress ☐ Yes ☐ No

Frequent sadness ☐ Yes ☐ No

Frequent anger or irritability ☐ Yes ☐ No

Taking medications ☐ Yes ☐ No

Fear of medical problems ☐ Yes ☐ No

Ages 1 ½ to 6 years: frequently clingy, difficulty separating, temper tantrums, behavior that is difficult to manage_______________________ ☐ Yes ☐ No

Infants/toddlers: trouble establishing sleeping and eating routines, very difficult to comfort ☐ Yes ☐ No

Has your child ever received counseling or therapy for any of the above problems or for any other reason(s)?
☐ Yes ☐ No

If yes, please explain: ____

____

Has your child taken any medication for any of the above problems or for any other reason(s)?
☐ Yes ☐ No

If yes, please explain: ____

____

Do you think your child has a problem sleeping? ☐ Yes ☐ No

If yes, do you think this is related to your child's health? Please explain: ______________________

____

Has your child's illness caused excessive stress or disruptions for the family? ☐ Yes ☐ No

In the past year, have family members had significant stresses other than your child's illness?
☐ Yes ☐ No

If yes, please list the top three:

1. ______________________

2. ______________________

3. ______________________

What is the biological mother's marital status?

- ☐ Single
- ☐ Married to biological father
- ☐ Separated from biological father
- ☐ Married to stepfather
- ☐ Living with someone
- ☐ Divorced
- ☐ Widowed

What is the biological mother's highest level of education?

- ☐ 8th grade or less
- ☐ 9th-12th grade
- ☐ High school graduate
- ☐ Some college or certification courses
- ☐ College graduate
- ☐ Graduate program or professional degree

What is the biological mother's current occupation? ______________________

What is the biological father's marital status?

- ☐ Single
- ☐ Married to biological mother
- ☐ Separated from biological mother
- ☐ Married to stepmother
- ☐ Living with someone
- ☐ Divorced
- ☐ Widowed

What is the biological father's highest level of education?

- ☐ 8th grade or less
- ☐ 9th-12th grade
- ☐ High school graduate
- ☐ Some college or certification courses
- ☐ College graduate
- ☐ Graduate program or professional degree

What is the biological father's current occupation? ______________________________

If the child is not living with either parent, please check all that apply to the legal guardian:

- ☐ Single
- ☐ Married
- ☐ Separated
- ☐ Living with someone
- ☐ Divorced
- ☐ Widowed

What is the legal guardian's highest level of education?

- ☐ 8th grade or less
- ☐ 9th-12th grade
- ☐ High school graduate
- ☐ Some college or certification courses
- ☐ College graduate
- ☐ Graduate program or professional degree

What is the legal guardian's current occupation?______________________________

____

Parent/Gaurdian Date

____

Clinician Date