National Jewish Health

Patient Label

Please use blue or black ink. Please write patient name on each page.

PEDIATRIC PATIENT QUESTIONNAIRE

Today's Date:_____/___/________

Patient Name____________________________Date of Birth_____/_____/_______Age __________

Name Patient Wants to Be Called ____

Sex assigned at birth: ☐ Male ☐ Female Current gender identity_____________Patient's pronouns _____________

Race/Ethnicity (check all that apply): ☐ American Indian/Alaska Native ☐ Asian ☐ Black or African American ☐ Hispanic ☐ Jewish Ashkenazi ☐ Jewish Sephardic ☐ Middle Eastern/Arabic ☐ Multiracial ☐ Native Hawaiian/Pacific Islander ☐ White ☐ Other (specify)______________________ ☐ Prefer not to say

Parents' marital status ☐ Married ☐ Divorced ☐ Separated ☐ Single ☐ Unknown
☐ Other (specify): ____________________________

Child lives with ☐ Both parents ☐ Father ☐ Mother ☐ Other (specify):___________________

PHYSICIAN AND PHARMACY INFORMATION

Primary Referring Physician

Name ______________________________

Address ______________________________

____

____

Phone ______________________________

Fax ______________________________

Email ______________________________

Referring Physician #2

Name ______________________________

Address ______________________________

____

Phone ______________________________

Fax ______________________________

Email ______________________________

Referring Physician #3

Name ______________________________

Address ______________________________

____

____

Phone ______________________________

Fax ______________________________

Email ______________________________

PHARMACY INFORMATION Local Pharmacy

Name ______________________________

Address ______________________________

____

Phone ______________________________

Fax ______________________________

Email ______________________________

Mail Order Pharmacy

Name ______________________________

Address ______________________________

Alternate Pharmacy

Name ______________________________

Address ______________________________

Phone ______________________ Phone ______________________

Fax ______________________ Fax ______________________

PAST MEDICAL HISTORY

Length of pregnancy: ☐ Full-term ☐ 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 with the pregnancy? If yes, specify ____________________________________

Were there problems with labor or delivery? If 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? ☐ No ☐ Yes

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 had any of the following illnesses?

	Yes	No		Yes	No
Chicken pox	☐	☐	Has your child been vaccinated?	☐	☐
RSV	☐	☐			

	Yes	No	Age of Onset	Number of Times
Ear infections	☐	☐	___________	___________
Sinus infections	☐	☐	___________	___________
Pneumonia	☐	☐	___________	___________
Croup	☐	☐	___________	___________

Other illnesses ☐ (specify)____

Has your child been hospitalized? ☐ No ☐ Yes

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? ☐ No ☐ Yes

If Yes, complete the following:

Ear Tube(s): Year________ Reflux surgery: Year_______ Tonsillectomy: Year ________
Appendectomy: Year________ Adenoidectomy: Year________ Hernia Repair: Year ________
Sinus Surgery: Year_______ Other: (specify)________________________________ Year ________

IMMUNIZATION HISTORY

Are your child's immunizations up to date? ☐ Yes ☐ No (explain) ______________________

____

Did your child have a flu shot this year? ☐ Yes

ALLERGY HISTORY

Is your child allergic to foods? If Yes, mark all that apply.

☐ Milk ☐ Egg ☐ Soy ☐ Wheat ☐ Peanuts ☐ Tree nuts (i.e. walnuts, pecans, etc.)

☐ Shellfish ☐ Fish ☐ Other (specify) ____

____

____

	Yes	No	Unknown
Is your child allergic to animals? ☐ Cats ☐ Dogs ☐ ________________	☐	☐	☐
Is your child allergic to medications?	☐	☐	☐
Specify ___________________________________			
Is your child allergic to ☐bee ☐ wasp ☐ yellow jacket ☐ hornet sting?☐		☐	☐
Is your child allergic to ☐ ant stings? ☐mosquitoes?	☐	☐	☐
Does your child have ☐atopic dermatitis ☐ eczema?	☐	☐	☐
Does your child have frequent hives or swelling?	☐	☐	☐
Does your child have nasal allergies?	☐	☐	☐

If Yes, when? (mark all that apply) ☐ Spring ☐ Summer ☐ Fall ☐ Winter

	Yes	No	Unknown
Does your child have eye symptoms from allergies?	☐	☐	☐

If Yes, when? (mark all that apply) ☐ Spring ☐ Summer ☐ Fall ☐ Winter

FAMILY MEDICAL HISTORY

Child's Father: Age_______years Occupation:____

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

☐ No allergies ☐ Allergy to animals_______________ ☐ Asthma
☐ Food allergy_____________ ☐ Hay fever ☐ Insect sting allergy
☐ Latex allergy ☐ Medication allergy_______________ ☐ Eczema

Child's Mother: Age______years Occupation:____

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

- ☐ No allergies ☐ Allergy to animals_______________ ☐ Asthma
- ☐ Food allergy_____________ ☐ Hay fever ☐ Insect sting allergy
- ☐ Latex allergy ☐ Medication allergy_______________ ☐ Eczema

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 ☐ Allergy to animals_______________ ☐ Asthma
- ☐ Food allergy_____________ ☐ Hay fever ☐ Insect sting allergy
- ☐ Latex allergy ☐ Medication allergy_______________ ☐ Eczema

Sibling 2: Age______years ☐ Female ☐ Male

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

- ☐ No allergies ☐ Allergy to animals_______________ ☐ Asthma
- ☐ Food allergy_____________ ☐ Hay fever ☐ Insect sting allergy
- ☐ Latex allergy ☐ Medication allergy_______________ ☐ Eczema

Sibling 3: Age______years ☐ Female ☐ Male

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

- ☐ No allergies ☐ Allergy to animals_______________ ☐ Asthma
- ☐ Food allergy______________ ☐ Hay fever ☐ Insect sting allergy
- ☐ Latex allergy ☐ Medication allergy______________ ☐ Eczema

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

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

Specify ____

HOME ENVIRONMENTAL HISTORY

What type of dwelling does the child live in? ☐ Apartment ☐ Condo ☐ House ☐ Townhouse

☐ Mobile home ☐ Other (specify): ____

What year was the current residence built? ___________Or age in years _________years

How long has the child lived in the current residence? ______Years ______Months

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

☐ Finished ☐ Unfinished ☐ Dry ☐ Damp ☐ Flood damage

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

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

☐ Curtains ☐ Venetian blinds ☐ Other (specify) ______________________________

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

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

How old is the mattress?____________years/months

How many stuffed animals are in the bedroom? ______

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 ☐ Indoor/Outdoor ☐ In bedroom

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

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

☐ Other (specify):

________________: _____ ☐ Indoor ☐ Outdoor ☐ Indoor/Outdoor ☐ In bedroom

________________: _____ ☐ Indoor ☐ Outdoor ☐ Indoor/Outdoor ☐ In bedroom

SOCIAL HISTORY

1. What grade is your child in?__________ ☐ Not applicable
2. Is your child home-schooled? ☐ YES ☐ NO
3. Does your child attend daycare? ☐ YES ☐ NO
   How many hours per week?________hours
   How many children are in his/her daycare? ______
4. Does your child have problems in school with learning or with teachers? ☐ Yes ☐ No
5. Is your child in special education classes? ☐ Yes ☐ No
   (If YES, please bring an individualized education plan: IEP)
6. Has your child had psychological testing? ☐ Yes ☐ No
   (If YES, please bring a copy of the report)
7. What are your child's hobbies/interests? ____
8. Does your child have any of the following difficulties or problems?
   a. Making or keeping friends ☐ YES ☐ NO
   b. Paying attention ☐ YES ☐ NO
   c. Overly active ☐ YES ☐ NO
   d. Frequent worrying ☐ YES ☐ NO
   e. Frequent stress ☐ YES ☐ NO
   f. Frequent sadness ☐ YES ☐ NO
   g. Frequent anger or irritability ☐ YES ☐ NO
   h. Taking medications ☐ YES ☐ NO
   i. Fear of medical procedures ☐ YES ☐ NO
9. Has your child ever received any counseling or therapy for any of these problems? ☐ YES ☐ NO
   (If YES, which one(s)? ____

10. Has your child ever received any medication for any of these problems? ☐ YES ☐ NO
    (If YES, which one(s)? ____
11. Has your child's illness caused excessive stress or disruptions for the family? ☐ YES ☐ NO
12. Do you think your child has a problem sleeping? ☐ YES ☐ NO
    (If YES, is this related to your child's health (e.g., itching, wheezing, pain)? ☐ YES ☐ NO

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-daytime ☐ Shortness of breath-nighttime
☐ 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): ____

Feeding and Nutrition:
Do you have any concerns about your child's weight or height?
☐ Weight loss ☐ Poor weight gain ☐ Too short ☐ Too thin ☐ Overweight

Does the child have?
Difficulty feeding? ☐ 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 ☐ Menses: Onset:______years

☐ Other (specify) _______________

Muscles and Bones ☐ Fractures ☐ Back pain ☐ Joint pains ☐ Muscle pain

☐ Muscle weakness ☐ Other (specify) _______________

Neurologic ☐ Concentration problems ☐ Difficulty walking ☐ Headaches

☐ Numbness ☐ Tremors ☐ Seizures ☐ Weakness

☐ Other (specify) _______________

Skin ☐ Easy brusing ☐ 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 ☐ Difficulties falling asleep ☐ Multiple night awakenings

☐ Frequent or loud snoring ☐ Stopping breathing during sleep ☐ Morning headaches

☐ Restless sleep (kicking, jerking, twitching) ☐ Difficulty waking in the morning

☐ Discomfort or pain in legs at bedtime/during the night ☐ Other (specify) _______________

MEDICATIONS

What medications does your child take?

Medication Name	Dose	How often is your child supposed to be taking this medication: A: TWICE a day B: ONCE a day C: 3-4 times a week D: Once a week E: Once a month F: As needed G: Others	How often refilled? A: monthly B: every 90 days C: once a year	Last refilled
Steroid Inhalers				
☐ Azmacort				
☐ Asmanex				
☐ Alvesco				
☐ Aerobid				
☐ Flovent HFA OR DISKUS				
☐ Pulmicort Flexhaler				
☐ Pulmicort/Budesonide Respule				
☐ Qvar				
Fast-acting Inhalers				
☐ Albuterol				
☐ Ventolin				
☐ Atrovent				
☐ Proair				
☐ Proventil				
☐ Xopenex				
☐ Combivent				
☐ Albuterol				
☐ Ventolin				
☐ Atrovent				
Long-acting Bronchodilators				
☐ Spiriva				
☐ Incruse				
Combination Medications (Inhaled Steroid and Long Acting Bronchodilator)				
☐ Advair HFA				
☐ Advair DISKUS				
☐ AirduoDISKUS				
☐ Symbicort HFA				
☐ Dulera HFA				

Combination Medications (Inhaled Steroid and Long Acting Bronchodilator) - Continued				
☐ Wixela				
☐ Trelegy				
☐ Breo				
Leukotriene Modifying Agents				
☐ Singulair				
☐ Accolate				
☐ Zyflo				
Oral Steroids				
☐ Prednisone, Deltasone, Medrol				
☐ Prelone, Pediapred, Orapred				
Other Medications				
☐ Theophylline				
☐ Xolair				
☐ Allergy Shots				
☐ Biologic				
OTHERS:				

Medication Name	Dose	How often is your child supposed to be taking this medication A: TWICE a day B: ONCE a day C: 3-4 times a week D: Once a week E: Once a month F: As needed G: Others	How often refilled? A: monthly B: every 90 days C: once a year	Last refilled
Antihistamines				
☐ Allegra				
☐ Benadryl				
☐ Hydroxyzine				
☐ Clarinex				
☐ Claritin				
☐ Xyzal				
☐ Zyrtec				

Nose Spray				
☐ Saline				
☐ Astelin				
☐ Flonase				
☐ Nasacort AQ				
☐ Nasonex				
☐ Rhinocort AQ				
☐ Veramyst				
☐ Zantac/Ranitidine				
☐ Proton pump inhibitors				
☐ Epipen				
☐ Ointments				
☐ Others				

Parent Signature ________________ Date ________ Time ________

Clinician Signature ________________ Date ________ Time ________