Children's Hospital Boston

LABEL OR PRINT
NAME
CH MRN
DOB GENDER M F

151689

RESPIRATORY RETURN APPOINTMENT PATIENT / FAMILY QUESTIONNAIRE

Division of Respiratory Diseases

To help you/your child's visit be as efficient as possible, please answer these questions.

Patient's name _____ Date_____

Your name _____

Your relationship to Patient _____

Pediatrician: _____

Pediatrician's Address: _____

_____

Date of last Pulmonary visit:_____ Location: _____ Physician: _____

Interval History:

Please list medicines that you/your child have been taking for respiratory problems

Name Dose Frequency

1)_____

2)_____

3)_____

4)_____

Please list medication allergies:

_____

What **symptoms** have been present within the past 2 weeks? Please check all that apply.

☐ Cough ☐ Wheeze ☐ Shortness of breath ☐ Fever

☐ Chest pain ☐ Heartburn ☐ Nasal congestion

Have the above symptoms been worse at night? ☐ Yes ☐ No

Have these symptoms been worsened by any activity (eating, exercise)? ☐ Yes ☐ No

Do you measure **peak flows?** ☐ Yes ☐ No

If Yes: Normal range: _____ Lowest value since last visit: _____

Since the time of your last visit have you/your child been seen in the **emergency room**? ☐ Yes ☐ No

If Yes, Date:_____ Location: _____

What was done? _____

CHILDREN'S HOSPITAL BOSTON, 300 LONGWOOD AVE., BOSTON, MA 02115

Rev 12/09

151689

LABEL OR PRINT
NAME

CH MRN

Have you/your child received **oral steroids** (Orapred, Prednisone) since their last pulmonary visit? ☐ Yes ☐ No

If Yes, Date(s): _____

Have you/your child been treated with **antibiotics** at any time since your last pulmonary appointment? ☐ Yes ☐ No

If Yes, Name(s) of antibiotics and Date(s) of Treatment: _____

_____

Have you/ has your child seen any other specialists since the time of their last pulmonary appointment? ☐ Yes ☐ No

If yes, Name(s) and Specialty: _____

_____

Review of Symptoms:

List any new or recently more active non-respiratory symptoms (e.g., nasal congestion, heartburn, etc.):

_____

_____

Family History:

Please describe any *new* information regarding medical diagnoses of other extended family members (current illnesses, recent diagnoses, etc):

_____

_____

_____

Home Environment:

Please describe any *recent changes* in your home environment (construction, new pets, new household members, change of school, etc):

_____

_____

_____

Have you/ has your child received the flu shot? ☐ Yes ☐ No

Are immunizations current? ☐ Yes ☐ No

_____
Patient/Parent/Guardian Signature

_____ _____
Physician Signature (confirming review with patient/parent/guardian) Date