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: ___________________________________________________________________________

Respiratory History:
What is the patient’s respiratory problem?
____________________________________________________________________________________

Recent Symptoms: What symptoms has your son/daughter been having within the past 6 weeks?
(Please check all that you’ve seen or heard)
  □ Cough  □ Wheeze  □ Labored breathing  □ Shortness of breath  □ Snoring
  □ Cold air   □ Dust   □ Activity/Exercise
  □ Mold   □ Viral infections   □ Smoke   □ Pets

Are your child’s symptoms worse with exposure to: (please check all that apply)
  □ Cold air   □ Dust   □ Activity/Exercise
  □ Mold   □ Viral infections   □ Smoke   □ Pets

Are the symptoms worse:
  In a particular season? □ Yes □ No  If Yes, which season(s)?________________________
  At night? □ Yes □ No
  During eating? □ Yes □ No
  After eating? □ Yes □ No

Has your child ever been treated with inhaled or nebulized medications? □ Yes □ No
If so, please list the names of these medications (Please continue on the back of this page if necessary)
_______________________________________________________________________________
Has it helped? □ Yes □ No
_______________________________________________________________________________
Has it helped? □ Yes □ No
_______________________________________________________________________________
Has it helped? □ Yes □ No

Does your child have a spacer? (ex: Aerochamber, Inspirease) □ Yes □ No

Does your child have a peak flow meter? □ Yes □ No
If Yes, Normal range:________________________

Lowest peak flow in last 3 months: ___________  When: ___________
What medicines has your child been taking within the past week?

<table>
<thead>
<tr>
<th>Name</th>
<th>Dose</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>1)</td>
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<td>2)</td>
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<td>4)</td>
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<tr>
<td>5)</td>
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</tbody>
</table>

Please list medication allergies:

__________________________________________________________________________________________

Respiratory History (cont)

Has your child been treated with oral steroids (Orapred, Prednisone)  □ Yes  □ No

If Yes, how many times within the past year? _______ Were they helpful? □ Yes  □ No

Has your child been treated with antibiotics in the last 3 months?  □ Yes  □ No

Name of antibiotic: ___________________________ Dates of treatment: ____________________________

Has your child been seen in an emergency room due to difficulty breathing?  □ Yes  □ No

If Yes, most recent Date: ___________ Location: _______________________________________________

What was done? _________________________________________________________________________

Has your child ever had a chest x-ray?  □ Yes  □ No

If Yes: Where? ___________________________ When?___________ Do you have it today? □ Yes  □ No

IF YOUR CHILD HAS PREMATURE LUNG DISEASE, PLEASE FILL OUT THIS SECTION:

Birth history:

Birth hospital: ____________________________________________

Gestational age at birth _______weeks

Length of hospitalization: _______ weeks

Neonatal Respiratory History:

Ventilated until _______ weeks/months of age

Pneumonia after birth? □ Yes  □ No

Did your child have a pneumothorax? □ Yes  □ No

Did your child receive Surfactant? □ Yes  □ No

Length of Oxygen therapy _____ days / weeks / months

(Please check one)

□ Current Oxygen requirements ______LPM  □ Usual Oxygen saturation (if known): _______

Other testing/studies:

Cranial ultrasound: Date _______ Results ________________________________________________

Hearing screen: Date _______ Results ________________________________________________

Eye exam: Date _______ Results ________________________________________________

Nutrition:

Type of milk: Breast milk/ Formula  (please circle)

Ounces per day _______ Calories per ounce _______

Other Supplements: ________________________________________________________________

Past Medical History:
Birth History:

- Full Term or premature (check one) 
- Vaginal Delivery or Cesarean Section (please check one)

Please list any problems with birth and delivery:

Does your child receive a yearly flu shot? □ Yes □ No

Are immunizations current? □ Yes □ No

Is your child allergic to any foods? □ Yes □ No

If Yes, to which one(s):

Has your child ever been evaluated by an allergist? □ Yes □ No

If Yes, what is that doctor’s name? __________________________________________

If Yes, what were the results of allergy testing?
________________________________________________________________________
________________________________________________________________________

Has your child ever been hospitalized or had surgery? □ Yes □ No (If Yes, please list below)

Hospital Approximate Dates Reason for Hospitalization
________________________________________________________________________
________________________________________________________________________

Review of Systems:

Has the patient ever been diagnosed with any of the following? If yes, please check any that apply and explain in the space provided. Is your family physician aware of any symptoms/illnesses that you have checked below? □ Yes □ No

<table>
<thead>
<tr>
<th>SYSTEM</th>
<th>NO</th>
<th>YES</th>
<th>SYSTEM</th>
<th>NO</th>
<th>YES</th>
<th>SYSTEM</th>
<th>NO</th>
<th>YES</th>
<th>SYSTEM</th>
<th>NO</th>
<th>YES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Birth History</td>
<td></td>
<td></td>
<td>Gastrointestinal</td>
<td></td>
<td></td>
<td>Neurologic</td>
<td></td>
<td></td>
<td>Genitourinary</td>
<td></td>
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<tr>
<td>Normal</td>
<td></td>
<td></td>
<td>Diarrhea</td>
<td></td>
<td></td>
<td>Seizures</td>
<td></td>
<td></td>
<td>Kidney Disease</td>
<td></td>
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<tr>
<td>Premature</td>
<td></td>
<td></td>
<td>Constipation</td>
<td></td>
<td></td>
<td>Weakness</td>
<td></td>
<td></td>
<td>Frequent urine infection</td>
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<tr>
<td>Cesarean</td>
<td></td>
<td></td>
<td>Rectal Bleeding</td>
<td></td>
<td></td>
<td>Migraines</td>
<td></td>
<td></td>
<td>Deafness</td>
<td></td>
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<tr>
<td>Prematurity</td>
<td></td>
<td></td>
<td>Hearburn/acid taste</td>
<td></td>
<td></td>
<td>Previous stroke</td>
<td></td>
<td></td>
<td>Psychosocial</td>
<td></td>
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<tr>
<td>Apnea/Bradycardia</td>
<td></td>
<td></td>
<td>Trouble swallowing</td>
<td></td>
<td></td>
<td>Musculoskeletal</td>
<td></td>
<td></td>
<td>Alcoholism</td>
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<tr>
<td>Intubation</td>
<td></td>
<td></td>
<td>Nausea</td>
<td></td>
<td></td>
<td>Muscle Disease</td>
<td></td>
<td></td>
<td>Substance Abuse</td>
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<tr>
<td>BPD</td>
<td></td>
<td></td>
<td>Vomiting</td>
<td></td>
<td></td>
<td>Arthritis</td>
<td></td>
<td></td>
<td>Depression</td>
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<tr>
<td>ECMO</td>
<td></td>
<td></td>
<td>Abdominal Pain</td>
<td></td>
<td></td>
<td>Neck pain</td>
<td></td>
<td></td>
<td>Anxiety disorders</td>
<td></td>
<td></td>
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<tr>
<td>Respiratory</td>
<td></td>
<td></td>
<td>Ear, Nose, &amp; Throat</td>
<td></td>
<td></td>
<td>Back pain</td>
<td></td>
<td></td>
<td>Cardiac</td>
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<tr>
<td>Asthma</td>
<td></td>
<td></td>
<td>Loose Teeth</td>
<td></td>
<td></td>
<td>Blood Disorders</td>
<td></td>
<td></td>
<td>High blood pressure</td>
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<tr>
<td>Pneumonia</td>
<td></td>
<td></td>
<td>Nosebleeds</td>
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<td></td>
<td>Skin</td>
<td></td>
<td></td>
<td>Low blood pressure</td>
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<tr>
<td>Bronchitis</td>
<td></td>
<td></td>
<td>Nasal congestion</td>
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<td></td>
<td>Eczema/rash</td>
<td></td>
<td></td>
<td>Irregular heartbeat</td>
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<tr>
<td>Chronic Cough</td>
<td></td>
<td></td>
<td>Itchy/burning eyes</td>
<td></td>
<td></td>
<td>Bruises</td>
<td></td>
<td></td>
<td>Chest pain</td>
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<tr>
<td>Cystic Fibrosis</td>
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<td></td>
<td></td>
<td>Ophthalmic</td>
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<td></td>
<td>Please list below:</td>
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<tr>
<td>Hoarseness</td>
<td></td>
<td></td>
<td>Endocrine/Metabolic</td>
<td></td>
<td></td>
<td>Cataracts</td>
<td></td>
<td></td>
<td>Any symptoms/diseases not listed above?</td>
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<tr>
<td>Tracheostomy</td>
<td></td>
<td></td>
<td>Diabetes</td>
<td></td>
<td></td>
<td>Glaucoma</td>
<td></td>
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<tr>
<td>Thyroid Disorders</td>
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<td></td>
<td>Blindness</td>
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</tbody>
</table>
Have your child’s growth and development been normal?  ☐ Yes  ☐ No
If No, please describe, e.g., small, underweight, specific developmental delays
_____________________________________________________________________________________

Family History:
Please list the ages of the patient’s brothers and sisters: _________________________________________
Do other members of your family have:

<table>
<thead>
<tr>
<th>Condition</th>
<th>Relation to patient</th>
<th>Condition</th>
<th>Relation to patient</th>
<th>Condition</th>
<th>Relation to patient</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asthma</td>
<td>☐ Yes ☐ No</td>
<td>Emphysema</td>
<td>☐ Yes ☐ No</td>
<td>Kidney Problems</td>
<td>☐ Yes ☐ No</td>
</tr>
<tr>
<td>Seasonal Allergies</td>
<td>☐ Yes ☐ No</td>
<td>Immune Problems</td>
<td>☐ Yes ☐ No</td>
<td>Bleeding Problems</td>
<td>☐ Yes ☐ No</td>
</tr>
<tr>
<td>Recurrent Pneumonia</td>
<td>☐ Yes ☐ No</td>
<td>Breast Cancer</td>
<td>☐ Yes ☐ No</td>
<td>Ulcerative Colitis</td>
<td>☐ Yes ☐ No</td>
</tr>
<tr>
<td>Cystic Fibrosis</td>
<td>☐ Yes ☐ No</td>
<td>Colon/ Rectal Cancer</td>
<td>☐ Yes ☐ No</td>
<td>Crohn’s Disease</td>
<td>☐ Yes ☐ No</td>
</tr>
<tr>
<td>Recurrent Bronchitis</td>
<td>☐ Yes ☐ No</td>
<td>Stomach Cancer</td>
<td>☐ Yes ☐ No</td>
<td>Heart Disease</td>
<td>☐ Yes ☐ No</td>
</tr>
<tr>
<td>Recurrent Sinusitis</td>
<td>☐ Yes ☐ No</td>
<td>Ovarian Cancer</td>
<td>☐ Yes ☐ No</td>
<td>Other Respiratory Illness</td>
<td>☐ Yes ☐ No</td>
</tr>
</tbody>
</table>

Home Environment:
Are any of the following in your child’s regular environment (home, daycare, school, relative’s home)
☐ Pets (please check): ☐ Dog  ☐ Cat  ☐ Bird  ☐ Hamster  ☐ Gerbil  ☐ Other
☐ Rodents (mice, rats)  ☐ Stuffed animals on his/her bed  ☐ Cigarette smoke
☐ Fireplace or wood stove  ☐ Mold or mildew you can see or smell  ☐ Cockroaches

Flooring: in the general living areas (ex: carpet, hardwood, linoleum) ________________________________
Flooring in patient’s bedroom:
Do you have a basement?  ☐ Yes ☐ No  Would you describe it as damp?  ☐ Yes ☐ No
What is the approximate age of your home? __________________________________________
Type of heat: (please check)  ☐ Forced hot water  ☐ Forced hot air  ☐ Electric baseboard
Do you have dust mite covers on your child’s bedding?  ☐ Yes ☐ No
Does your child attend daycare?  ☐ Yes ☐ No
Do you use a humidifier?  ☐ Yes ☐ No

Thank you for providing all this information; it will help us help your child!

Patient/Parent/Guardian Signature
__________________________________________________________  ____________________

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