NAME: ______________________________________

DOB: ______________

NEW PATIENT INFORMATION

We appreciate the opportunity to partner with you in the health of your child. We ask you to complete this information carefully and legibly. Thank you!

Previous Diagnosis: RAD ASTHMA BPD/CHRONIC LUNG REFLUX ECZEMA ALLERGIC RHINITIS OTHER ____________

YOUR CHILD'S RESPIRATORY (BREATHING) COMPLAINTS

When your child is having issues, please describe the symptoms (circle all that apply):

COUGH WHEEZING CHEST TIGHTNESS CHEST RATTLES SHORTNESS OF BREATH NOISY BREATHING

INCREASED WORK TO BREATHE CHEST PAIN DECREASED TOLERANCE FOR EXERCISE RETRACTIONS

Do these symptoms occur at: ___REST __ WITH ACTIVITY?

When did these symptoms originally begin? ______________________

When was the last time your child was completely clear of all of these respiratory symptoms including cough? ____________________________________

What is the longest your child has been completely clear of any respiratory symptoms including cough, in the last 12 months,? ____

FOR RESPIRATORY (BREATHING) SYMPTOMS ONLY:

Overnight hospitalizations? ____NO ____YES When/How Many? __________________________

- **Did the visit require intensive care?** ______NO _____YES

Emergency room visits in the last 12 months? ____NO ____YES How Many? _______________

Acute doctor visits (as opposed to regular check-ups) in last 12 months?

____NO ____YES How Many? _____________

In a typical week, do symptoms disturb sleep? ____NO ____YES How many nights? ________

disturb activity? ____NO ____YES How many days?_______

When your child is having nose symptoms:

Runny: ____year round continuous ____ seasonally continuous ___ intermittent

Stuffy: ____year round continuous _____seasonally continuous ____intermittent

MEDICATIONS:

List any current medications your child is taking for respiratory symptoms:

____

____

____

____

List any previous medications you have tried to relieve__ these symptoms:

____

____

Does your child have ____dry/itchy skin____sensitive skin______recurrent rashes?

Has your child every had any Allergy testing done before? ___YES __NO

Other than those on the previous page, please list any recent symptoms or complaints:

Health overall – for example change in appetite, chills, fatigue, weight gain or loss, etc.

____NO _____YES (describe) ____

Eyes – for example visual changes, blurred vision, eye drainage, sensitivity to light, etc.

____NO _____YES (describe) ____

Ears, Nose, and Throat – for example sore throat, hearing changes, sinus drainage, etc.

____NO _____YES (describe) ____

Heart – for example heart murmur, heart palpitations, chest tightness, dizziness, etc.

____NO _____YES (describe) ____

Stomach and Intestines – for example abdominal pain, change in stools, heartburn, indigestion

____NO _____YES (describe) ____

Bladder or Kidney – for example urinary problems, blood in urine, frequent bladder infections, etc.

____NO _____YES (describe) ____

Muscle or Skeleton – for example arthritis, back pain, joint stiffness or pain, weakness, etc.

____NO _____YES (describe) ____

Skin – for example change in moles, acne, rashes, sores, etc.

____NO _____YES (describe) ____

Neurological – for example fainting, headaches, memory problems, numbness or tingling, etc.

____NO _____YES (describe) ____

Psychological – for example anxiety, depression, mood swings, poor concentration, etc.

____NO _____YES (describe) ____

Diabetes/Thyroid – for example cold or heat intolerance, hair loss, excessive thirst, etc.

____NO _____YES (describe) ____

Bleeding/Anemia – for example blood clotting problems, easy bruising, excessive bleeding, etc.

____NO _____YES (describe) ____

Other?

PATIENT MEDICAL HISTORY – SINCE BIRTH

Please list any symptoms, complaints, or diagnosis in the following areas since birth:

Health Overall? ____NO ____YES (describe) ____

Eyes? ____NO ____YES (describe) ____

Ears, Nose, and Throat? ____NO ____YES (describe) ____

Heart? ____NO ____YES (describe) ____

Stomach and Intestines? ____NO ____YES (describe) ____

Bladder or Kidney? ____NO ____YES (describe) ____

Muscle or Skeleton? ____NO ____YES (describe) ____

Skin? ____NO ____YES (describe) ____

Neurological? ____NO ____YES (describe) ____

Psychological? ____NO ____YES (describe) ____

Diabetes/Thyroid? ____NO ____YES (describe) ____

Bleeding/Anemia? ____NO ____YES (describe) ____

Other Comments? ____

____

PAST SURGERIES? _____None _____Yes, Please describe: ____________________________

____

____

PATIENT SOCIAL ENVIRONMENT

Please circle the answer which best represents the patient's current living arrangements?

With: PARENTS MOTHER FATHER SPLIT TIME GRANDPARENT(S)

Is your family involved with the Department of Human Services in any capacity? _____NO

If yes, please describe: ____

Where does patient spend time during the day?

DAYCARE: (Number of days during week?) __________

PRESCHOOL: (Number of days during week?) __________

SCHOOL: (Number of days during week?) __________

BROTHERS? ____None Yes-Ages: ________

SISTERS? ____None Yes-Ages: _______

PATIENT ENVIRONMENTAL HISTORY – Information on home and neighborhood

CITY: ______________________________________

HOME?: SINGLE-FAMILY **What year was the house built?** ________

APARTMENT TRAILER DUPLEX

BASEMENT?: NONE UNFINISHED FINISHED **Is the basement** ____DAMP or ____DRY?

HOME CLIMATE CONTROL?: CENTRAL AIR WINDOW UNIT

CENTRAL FORCED HEAT RADIATOR HEAT BASEBOARD HEAT FIREPLACE

WOOD BURNING STOVE AIR PURIFIERS OTHER ______________________________

PATIENT'S BEDROOM: NUMBER OF BEDS IN ROOM ______

BEDS HAVE DUST MITE COVERS ____NO ____YES

NUMBER OF PEOPLE SLEEPING IN ROOM _______

FLOOR COVERINGS? WOOD CARPET AREA RUG

PETS?: NONE CAT(S) ______ DOG(S) ______ OTHER: __________

DO PETS HAVE ACCESS TO BEDROOM? ____________________

INDUSTRIAL OR AGRICULTURAL POLLUTION IN NEIGHBORHOOD?: _____NO

If yes, please describe? ____

SMOKER EXPOSURE: ____NO _____YES Who? __________________________

Does smoker limit direct contact by smoking outdoors only? ____________________

Does patient smoke? ____NO _____YES How often? ___________________________

PRIMARY CARE PHYSICIAN?: ____

Location?: ____

PREFERRED PHARMACY?: ____

Location?: ____

FAMILY MEDICAL HISTORY - Please circle any that apply for patient's immediate family and/or grandparents

RESPIRATORY	Asthma	Pulmonary Embolism	Pulmonary Hypertension	Sleep Apnea	Tuberculosis	Sarcoidosis	Emphysema	COPD	Cystic Fibrosis
EYES/VISION	Retinitis Pigmentosa	Osler's Disease	Blindness	Glaucoma	Acoustic Neuroma	Color Blindness			
EARS, NOSE, THROAT	Strabisms	Otosclerosis	Meniere's Disease	Allergic Rhinitis	Deafness	Macular Degeneration			
HEART	Arrhythmia IRREGULAR HEARTBEAT	Coronary Disease	Cardiac Murmurs	Congestive Heart Failure	Congenital Heart Anomaly	Hypertension ELEVATED BP	Myocardial Infarction	Hyper Lipidemia	
STOMACH/ INTESTINES	GERD	Hepatitis A, B, C	IBS	Barrett's Esophagus	Crohn's Disease	Esophageal Disorder			
BLADDER/ KIDNEY	Chronic Kidney Disease	Polycystic Kidney Disease	Renal Failure						
MUSCLE/ SKELETON	Fibromyalgia	Myopathy	Scoliosis	Rheumatoid Arthritis	Gout	Osteopenia	Polymyositis	Osteoarthritis	
SKIN	Eczema	Psoriasis	Seborrheic Dermatitis		**IMMUNE**	Anaphylaxis	HIV/AIDS	Immuno-deficiency	
NEUROLOGIC	Cerebral Palsy	Epilepsy	Mental Retardation	Migraines	Multiple Sclerosis	Seizure Disorder	Stroke	Headaches	
PSYCHIATRIC	ADD	ADHD	Bipolar Disorder	Depression	Eating Disorder	Anxiety			
ENDOCRINE	Addison's Disease	Diabetes Type 1	Diabetes Type 2	Hyper-thyroidism	Hypo-thyroidism	Cushing's Disease			
BLOOD	Hemophilia	Pernicious Anemia	Sickle Cell Disease	DVT	Thrombo-cytopenia	Factor Vill Deficiency			
CANCER	Brain Tumor	Breast Cancer	Cervical Cancer	Leukemia	Colon Cancer	Lung Cancer	Lymphoma		

Other? ____

Is child adopted? _____NO ______YES