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: _____

_____
Initials

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 ____/_____	

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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

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				

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): _____

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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

_____
Initials

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? _____

_____
Initials

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: _____

_____

_____
Initials

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

_____
Initials

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