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 _____
_____
_____
Phone _____
Fax _____

Alternate Pharmacy

Name _____
Address _____
_____
_____
Phone _____
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
Chicken pox	☐	☐
RSV	☐	☐

Has your child been vaccinated? ☐ Yes ☐ No

	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? _____

M M / D D / Y Y Y Y

_____ 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			
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 (**s**oiling 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