National Jewish Health® for kids

1400 Jackson Street
Denver, CO 80206
njhealth.org

Greetings!

Thank you for your interest in the National Jewish Health Pediatric Day Program. We are truly looking forward to working with you and your child.

The Pediatric Day Program is a complete program of care and education. A dedicated team of specialists will work with you and your family to provide the best individualized care for your child.

Your child's dedicated team will include a medical doctor, a doctor in-training to become a specialist in allergy and immunology or an experienced nurse practitioner or physician's assistant, registered nurses and a child life specialist. A behavioral health provider or other specialists may be added to the team as necessary.

Our unique program allows the team to observe and monitor your child's symptoms throughout the day. This way we can make an accurate diagnosis and develop a successful individualized treatment plan. You will have a "home base" within the Pediatric Care Unit. Here you check in each day and review they day's schedule with your child's team. During your stay, you and your child will attend medical appointments, have necessary tests performed and actively participate in patient education.

At National Jewish Health we pledge to always honor and respect your child's rights to the best of our ability and to provide the highest level of care possible.

In this packet you will find information to help you prepare for your visit to National Jewish Health, as well as information that will be useful during your stay. Please feel free to contact the Pediatric Administrative Coordinator at 303.398.1239, with any questions or concerns.

We look forward to seeing you soon.

The Day Program Team

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General Information

In Case of Emergency. Once you have arrived in Denver, if your child needs medical attention before the day of admission or while you are not on the National Jewish Health campus, call the 24/7 Pediatric Phone Triage service at 303.398.1239. One of our nurses will help you. Tell the nurse that your child is here for the Day Program. Walk-in triage care is available in our Immediate Care clinic. It is open seven days a week, from 8 a.m. to 7 p.m. **If your child is having a significant breathing problem or other emergent condition, call 911.**

Arrival Time. Your family should arrive at the time given by your Patient Administrative Coordinator. Report to the admissions desk on the first floor in the Center of Outpatient Health. If your arrival time will be delayed, please call 303.398.1239.

Patient Safety. It is necessary for us to take special precautions to protect all of our patients and families from contagious infections. If your child shows any signs or symptoms of infection, they may be placed in isolation until this can be confirmed by our diagnostic laboratory. We apologize in advance for any inconvenience. This is to protect other patients and family members who may have compromised immune systems.

Length of Stay. The length of stay will depend on your child's illness and their diagnostic needs.

Where to Stay. Please visit **www.njhealth.org** for a list of local hotels and non-profit facilities that offer special discounted rates for our patients. If your child's team thinks your child needs to be monitored overnight, they will discuss that with you after your evaluation has begun.

Where You Will Be During the Day. The number of patients we have in the Day Program varies day to day. There may not always be a private room for you and your child. You will have access to the common areas on the unit. However, we will try to accommodate your needs to the best of our capability.

Family Members and Visitors. Certain tests/appointments only allow for the patient and/or their guardians to be present. Due to this, if siblings are present, additional care givers are required. There is no childcare provided, and all children must be supervised at all times by guardians or care givers.

Meals. "Grab and Go" food items are available. Parents can purchase meals in our cafeteria to eat with their children on the unit. If you prefer to bring food from off campus you will have access to a refrigerator and a microwave.

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General Information continued

Parking. Free patient parking is available Monday-Sunday, 24 hours a day. We also offer valet services to our patients and visitors, Monday-Friday 8:00 a.m. to 4:30 p.m.

Pharmacy. National Jewish Health has an onsite pharmacy to provide prescription services for medications your physician may prescribe during your stay. The pharmacy can process most prescription insurance claims electronically as prescriptions are filled.

It is the patient's responsibility to verify prescription benefits with their insurance carriers. To reduce the amount of time it takes to fill prescriptions during your child's evaluation in the Day Program, we encourage you to verify coverage before you arrive.

Payment can be made using cash, check or major credit cards. Payment is required when prescriptions are filled. The pharmacy staff will be glad to answer any questions you may have regarding your medication or prescription charges by calling 303.398.1582 or visiting the pharmacy located in the main lobby of the Center of Outpatient Health Building. The pharmacy hours are Monday-Friday 8:30 a.m. to 5:30 p.m.

Patients Representative Program. The National Jewish Health Patient Representative Program is available to assist patients and families with special concerns that are not resolved by members of your patient's care team. You may contact the Patient Representative by calling 303.398.1076, or by dialing the in-house operator.

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Responsibilities for Parents and Patients

- Do not wear perfumes, colognes, aftershave, scented lotions, or scented hair products, as these can cause an allergic reaction in some of our patients. We are a fragrance-free facility.
- National Jewish Health is a non-smoking facility.
- Be aware of your schedule at all times and arrive on time to each appointment/test. Certain tests may not be able to be rescheduled if missed. Notify your Patient Administrative Coordinator at 303.398.1239 in advance if you cannot keep an appointment.
- Send all medical records to National Jewish Health in advance of your visit. Please see the Medical Records section for further direction.
- Complete the attached patient questionnaire and bring it with you on the first day of your appointments.
- Follow the guidelines found in the Preparing for Your Tests section.
- Be honest and direct about aspects of your life that relate to your child's illness and experience here. This helps your medical team complete a relevant evaluation and create a useful treatment plan for your child.
- Know the names and dosages of the medications your child is taking. Bring all the medications and medical devices your child is currently taking/using.
- Report any changes in your child's health to your doctor or nurse as soon as possible.
- As a courtesy to our patients, National Jewish Health verifies your insurance coverage. This does not guarantee your insurance will cover your child's appointments and testing. Please contact your insurance carrier if you have questions about your coverage.
- Your child may require testing at another health care facility. Our staff will assist you in making these arrangements. National Jewish Health is not responsible for verifying your insurance benefits at other facilities.
- Please be considerate of other patients' privacy at all times.
- Please keep track of your personal belongings and valuables. National Jewish Health is not responsible for any lost, stolen, or damaged items.

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Items to Bring for Day Program

All Patients:

- ☐ All current medications (prescription and over the counter) in the original containers (if possible) Health insurance policies and/or insurance card
- ☐ Guardian photo ID card
- ☐ Prescription card
- ☐ Any necessary referrals or authorizations required by your insurance company
- ☐ Any pertinent legal documents such as custody and/or divorce documents
- ☐ Comfortable clothing and shoes (appropriate for physical activity)
- ☐ Toiletries
- ☐ Security items i.e. blanket, teddy bear, etc.
- ☐ Homework if necessary

Please note Colorado weather can be unpredictable. While preparing for your visit please ensure that you have packed the appropriate seasonal items. Also, Denver is located one mile above sea level, so sunscreen is recommended year-round.

Eczema Patients Only:

- ☐ 12 pairs of long tube socks
- ☐ 3 sweat suits (sweat shirt and sweat pants) or 3 pairs of zip-up footie pajamas
- ☐ 3 pairs of thermal underwear if available or 4 light weight sleepers for infants and young children

See examples on the next page.

If your child uses any of the following, please also bring them:

- ☐ Peak flow meter, spacers for metered dose device (asthma patient)
- ☐ CPAP machine
- ☐ Ventilatory assist device Compressor-
- ☐ Nebulizer
- ☐ Special oxygen equipment (oximeter)
- ☐ Glucometer and test strips

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Items to Bring for Day Program continued

Eczema Patients Only – Please Bring the Following:

12 pairs long cotton tube socks

3 or more sets of sweat shirts/pants or fleece footie pajamas

3 or more sets of long underwear or cotton footie pajamas

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Preparing for Your Tests

Your doctor has recommended your child have certain tests as part of your evaluation at National Jewish Health. The most frequently ordered test is for allergies. Allergy testing can include up to 40-skin pricks per appointment. The testing is usually done on the back and is relatively painless. Try to avoid lotions, oils and creams on the back for this test. **All oral antihistamines will need to be stopped prior to testing because they can affect the results**. Check with your child's doctor before you stop any medicines.

Withhold (stop taking) oral antihistamines for the designated length of time before your appointment.

If your child is taking this medicine	Stop taking this medicine
Claritin® (Loratadine)	5 days before your appointment
Allegra® (Fexofenadine)	5 days before your appointment
Clarinex®(Desloratadine)	5 days before your appointment
Actifed®, Dimetapp® (Brompheniramine)	3-4 days before your appointment
Atarax®, Vistaril® (Hydroxyzine)	3-4 days before your appointment
Benadryl® (Diphenhydramine)	3-4 days before your appointment
Chlortrimeton® (Chlorpheniramine)	3-4 days before your appointment
Phenergan® (Promethazine)	3-4 days before your appointment
Tavist®, Antihist® (Clemastine)	3-4 days before your appointment
Actifed®, Aller-Chlor®, Bromfed®, Drixoral®, Dura-tab®, Novafed-A®, Onrade®, Poly-Histine-D®, Trinalin® Zyrtec® (Combination medicines) (Cetirizinei)	3-4 days before your appointment
Singulair® (Montelukast)	The night before your test

▶ If your child is taking an oral antihistamine that is not listed, hold the medicine for **3 - 4 days** before the appointment. If you are not sure if the medicine your child is taking is an antihistamine, ask your child's doctor, or call the Pediatric phone nurse at 303.398.1239.

▶ Continue to give your child all other medicine that they usually take.

ADM 129.0712

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Patient Financial Responsibility

National Jewish Health is committed to providing quality health care and service to all patients. We understand that billing and payment for health care services can be confusing and complicated. Knowing your insurance policy is vital to receiving the maximum benefits possible. Failure to meet your insurance requirements may result in partial or complete claim denial and/or a higher co-payment/or deductible. We request that you pay any insurance copayments, deductible, and/or coinsurance at the time of registration.

Please be aware, National Jewish Health is a hospital facility and the physicians are employees of the hospital. Therefore, in addition to a specialty physician co-payment, a hospital co-payment, deductible, and/or co-insurance may apply. If you have any questions about your financial responsibility, please contact your insurance carrier.

As a courtesy to patients and their families, National Jewish Health submits claims to most insurance carriers. To insure proper and prompt processing of your claim, it is important that all current insurance information be presented at the time of pre-registration and/or admission. Please have a copy of your insurance card and your driver's license or other form of identification with you when you check-in.

National Jewish Health is a specialty hospital. Consequently, many insurance plans require a referral in order to access health care at National Jewish Health. If your insurance plan has such a requirement, it is your responsibility to obtain a referral from your primary care physician and/or specialist physician. Referrals can be faxed to 303.270.2161.

If your insurance plan requires scheduled medical services to be pre-certified or pre-authorized, National Jewish Health will attempt to obtain such approval from the insurance plan or the entity responsible for utilization management. Failure to meet your insurance requirements may result in partial or complete claim denial or a higher copayment/or deductible, and you may be responsible for the remaining balance.

National Jewish Health staff are available to assist you in understanding your hospital insurance benefits. We attempt to verify your insurance benefits prior to medical services being completed. Estimates of your financial responsibility are based on the accuracy of this information. The insurance benefit information provided by your insurance plan is based on the latest information they have available. Please remember that your insurance plan benefits are a contract between you, your employer and your insurance company. It is in your best interest to know and understand your benefits.

In the event you do not have insurance coverage, or cannot pay the patient responsibility portion of your bill, you will be asked to speak with one of our financial counselors. Our financial counselors are trained to assist you in meeting your financial obligations. We offer a variety of payment plans and prompt payment discounts. We accept all major credit cards. Financial counselors can also assist you in applying for charitable or public assistance programs for which you may be eligible. This service is provided to you at no cost. However, your cooperation is essential to successfully qualify for these programs. You are still financially responsible for the medical services until you are qualified for one of the programs. Please contact our Patient Financial Counseling Office at 303.398.1065 with any questions prior to your visit.

Please remember that all of your copayments for prescriptions will be collected at the Pharmacy.

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How to Request Medical Records

If you want your medical records mailed to National Jewish Health, please do the following:

1. Complete the attached form.
2. Mail or hand deliver the attached form to your physician and/or hospital where services have been provided to you.

Please DO NOT mail the completed form to National Jewish Health.

Authorization to Release Protected Health Information National Jewish Health Information Management Department-Release of Information
1400 Jackson St, Denver, CO 80206 PH (303) 398-1580; FAX (303) 398-1211 or FAX (303) 398-1987

Section A

Full Name: _____ Medical Record #: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone #: _____ Date of Birth: _____

Section B

I hereby authorize: ☐ National Jewish Health

☐ Other: _____
Name/Title Organization

_____
Address

_____
City/State/Zip Phone Fax

Section C

Recipient(s): ☐ National Jewish Health **[Please complete all known fields for the recipient as requested.]**

☐ Other: _____
Name/Title Organization

_____
Address

_____
City/State/Zip **Phone** **Fax**

☐ Other: _____
Name/Title Organization

_____
Address

_____
City/State/Zip **Phone** **Fax**

Section D

Purpose of disclosure: ☐ Continuation of Care ☐ Insurance ☐ Legal ☐ Personal Use
☐ Other: **Authorization Expiration Date:**

Description of Information to be Used or Disclosed:

For Treatment Date(s) _____
☐ Clinic Summary/Consultation ☐ Cardiology Test ☐ Laboratory ☐ Pulmonary Test ☐ Procedure
☐ Radiology Reports ☐ Radiology Images CD
☐ Other: _____

Request Delivery (If left blank, a paper copy will be provided: ☐ Paper Copy ☐ Electronic Media, if available (CD/DVD)

☐ **Unencrypted Email**

☐ **Encrypted Email** ☐ @yahoo.com ☐ @gmail.com ☐ Other: @ _____

NOTE: In the event the facility is unable to accommodate an electronic delivery as requested, an alternative delivery method will be provided (e.g., paper copy). There is some level of risk that a third party could see your PHI without your consent when receiving unencrypted electronic media or email. We are not responsible for unauthorized access to the PHI contained in this format or any risks (e.g., virus) potentially introduced to your computer/device when receiving PHI in electronic format or email.

Per CRS, 25-1-801 the following fees may be charged for copies of medical records. Records will be provided to other health care providers at no charge. **PLEASE ALLOW 10 BUSINESS DAYS FOR PROCESSING.**

Section E

_____By **initialing** this area, I authorize the release of my health records that may include information indicating the presence of communicable or venereal diseases, which may include, but are not limited to: hepatitis, syphilis, gonorrhea and the human immunodeficiency virus, also known as Acquired Immune Deficiency Syndrome (AIDS or Human Immune Deficiency Virus (HIV).

_____By **initialing** this area, I authorize the release of my health records that may include information about behavioral and/or mental health services and/or treatment for alcohol and/or drug abuse.

My treatment, payment, enrollment or eligibility for benefits may not be conditioned by signing this authorization.
This request is made voluntarily and the information given is accurate to the best of my knowledge.
I may revoke this authorization at any time in writing, but if I do, it will have no effect on actions taken prior to receiving the revocation.
I understand that information disclosed pursuant to the authorization may be subject to disclosure by the recipient and is no longer protected by the HIPAA privacy rule.
Without my express revocation, unless otherwise indicated above this consent will automatically expire 180 days from the date signed below.

I have read the above and authorize the disclosure of my protected health information as stated.

Patient or Authorized Representative Signature Date Relationship

Please fax to 303-398-1211, or mail to National Jewish Health, HIM Dept, Rm L07, 1400 Jackson St, Denver, CO 80206

In our Notice of Privacy Practices, we informed you that we might share your protected health information verbally to those individuals involved in your care or payment for your care.

By completing this form, you may designate those individuals with whom we may discuss your routine health information such as lab results, future appointments and/or billing related questions.

1. **Patient: When is it okay to leave you a message about your health information?** (We will try to contact you directly if we have urgent or sensitive information.)
   - ☐ Never
   - ☐ On my voicemail at home #_____
   - ☐ On my voicemail at work #_____
   - ☐ On my voicemail on mobile phone #_____
2. **Alternate Patient Representative: With whom may we discuss your health information?** (Please remember this does not apply to calls made from our automated appointment reminder system to your phone number unless you request that we discontinue this service.)
   - ☐ No one
   - ☐ The people listed below:

Name	Relationship	Phone Number
Name	Relationship	Phone Number

3. **Content of Disclosure Preference: We will leave a message including detailed personal medical information unless otherwise specified below:** (Please indicate below the types of information about which you do not want us to leave a message.)

_____

4. **Pediatric Patients Third Party Preferences: May we communicate with your child's school, daycare or childcare provider about your child's health care? This may be inclusive of behavioral health disclosures.** ☐ Yes ☐ No ____ (Initials)
   a. Please specify alternate preference, if applicable:

_____

This consent will remain in effect until revoked by the patient/representative or when the minor patient reaches the age of majority or becomes emancipated. Please notify us of any changes.

Patient's Name for Initial Preference Designation | Date of Birth

Signature of Patient/Legal Personal Representative | Date/Time

Revocation of Communication Preferences Listed Above (Preferences Changes ONLY):

Revoke all preferences? ☐ Yes Change preferences? ☐ Yes. Indicate changes below:

Signature of Patient/ Legal Personal Representative | Date/Time

National Jewish Health®
Breathing Science is Life®

HIPAA Patient Request _CC

Patient label

Consent to Communicate Protected Health Information (PHI)

Referring Physician Information

Date of Birth:____________________**Patient:**____

In order to provide results and recommendations from your child's evaluation at National Jewish Health, to your child's physician at home, we need to have complete information. Please complete this form and return it to the Pediatric Services Administration Department when you arrive for your child's appointment.

Primary Care Physician (Last, First):______________________________

Address:____
(Street) (Suite #)

____
(City) (State) (Zip)

Telephone:______________________________________Fax:______________________

Specialist Physician (Last, First):___________________

Address:____
(Street) (Suite #)

____
(City) (State) (Zip)

Telephone:____________________________________ Fax:_________________________

Specialist Physician (Last, First):____

Address:____
(Street) (Suite #)

____
(City) (State) (Zip)

Telephone:____________________________________ Fax:_________________________

Specialist Physician (Last, First):____

Address:____
(Street) (Suite #)

____
(City) (State) (Zip)

Telephone:____________________________________ Fax:_________________________

Patient/Parent Signature: ____

Date: ___________________Time: _______________

National Jewish Health®
Breathing Science is Life.

Patient Label

Care Coordination Record _CC

Referring Physician Information

ADM 132 (01/25)

National Jewish Health for Kids

njhealth.org

At njhealth.org, we offer information about our clinical programs, current research, educational opportunities and the conditions we treat. You can be confident that the information provided on our site has been written and approved by our medical staff.

Online Services

- **Make Appointments** – request new or follow-up appointments
- **Appointment Questions** – Appointment questions answered by our expert staff
- **Ask-an-Expert** – Health questions answered by our lung line nurses
- **Pay Your Bill** – Secure bill payment by credit card or electronic check
- **Request Medical Records** – Securely request medical records
- **Patient Information** – lodging, directions, and more
- **Clinical Trials** – learn about and sign-up for clinical trial participation
- **Health Information** – Written and approved by our expert medical staff
- **Donate** – Make a difference with a one-time gift or learn about other ways to give
- **Referrals** – Doctor referrals for tests or appointments

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National Jewish Health for kids

PEDIATRIC PATIENT QUESTIONNAIRE

Please use blue or black ink. Please write patient name on each page.

Patient Name _____ **Today's Date** _____

Patient's Date of Birth __ __ (Month) __ __ (Day) __ __ __ __ (Year) **Age** _____

Sex ○ Male ○ Female ○ Nonbinary

Race (mark one only) ○ American Indian ○ Asian ○ Black or African American ○ Caucasian ○ Hispanic

○ Jewish Ashkenazi ○ Jewish Sephardic ○ Middle Eastern/Arabic ○ Other (specify) _____

○ Mixed (specify) _____

Parents' marital status ☐ Married ☐ Divorced ☐ Separated ☐ Single ☐ Unknown

☐ Other (specify): _____

Child lives with ☐ Both parents ☐ Parent 1 name _____

☐ Parent 2 name _____ ☐ Other name _____

PHARMACY INFORMATION

Local Pharmacy name _____

Address _____

Phone _____

Mail Order Pharmacy name _____

Address _____

Phone _____

Other Pharmacy name _____

Address _____

Phone _____

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?

Chicken pox ○No ○Yes Was your child vaccinated? ○No ○Yes Date _____

RSV ○No ○Yes

Ear infections ○No ○Yes Age first infection_____ Number of times_____

Sinus infections ○No ○Yes Age first infection_____ Number of times_____

Pneumonia ○No ○Yes Age first infection_____ Number of times_____

Croup ○No ○Yes Age first infection_____ Number of times_____

Other Illnesses Specify_____

Has your child been hospitalized? ○No ○Yes Number of times_____

Date of hospitalization __ __ (Month) __ __ (Day) __ __ __ __ (Year) Reason _____

Date of hospitalization __ __ (Month) __ __ (Day) __ __ __ __ (Year) Reason _____

Date of hospitalization __ __ (Month) __ __ (Day) __ __ __ __ (Year) Reason _____

Date of hospitalization __ __ (Month) __ __ (Day) __ __ __ __ (Year) Reason _____

Date of hospitalization __ __ (Month) __ __ (Day) __ __ __ __ (Year) Reason _____

PAST SURGICAL HISTORY

Has your child had any surgeries? ○No ○Yes If yes, complete the following:

Ear Tubes 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? ○No ○Yes (explain)_____

_____

Did your child have a flu shot this year? ○No ○Yes Date_____

ALLERGY HISTORY

Is your child allergic to foods? ○No ○Yes Mark all that apply ☐ Milk ☐ Egg ☐ Soy

☐ Wheat ☐ Peanuts ☐Tree nuts (walnuts, pecans, etc.) ☐ Fish ☐ Shellfish

Other (specify) _____

Is your child allergic to:

Cats ○No ○Yes ○Unknown Dog ○No ○Yes ○Unknown

Medications ○No ○Yes ○Unknown (specify)_____

Stings: ☐ Bee ☐ Wasp ☐ Yellowjacket ☐ Hornet ○No ○Yes ○Unknown

☐Ant bites/stings ○No ○Yes ○Unknown ☐Mosquito bites ○No ○Yes ○Unknown

Does your child have ☐atopic dermatitis ☐eczema? ○No ○Yes ○Unknown

Does your child have frequent hives or swelling? ○No ○Yes ○Unknown

Does your child have nasal allergies? ○No ○Yes ○Unknown

If yes, when? (mark all that apply) ☐Spring ☐Summer ☐Fall ☐Winter

Does your child have eye symptoms from allergies? ○No ○Yes ○Unknown

If yes, when? (mark all that apply) ☐Spring ☐Summer ☐Fall ☐Winter

FAMILY MEDICAL HISTORY

Child's Father Age_____years Occupation_____

Mark all of the following conditions that apply: ☐No allergies ☐Allergies to animals

☐Asthma ☐Food allergies ☐Hay fever ☐Insect sting allergy

☐Latex allergy ☐Medication allergy ☐Eczema

Child's Mother Age_____years Occupation_____

Mark all of the following conditions that apply: ☐No allergies ☐Allergies to animals

☐Asthma ☐Food allergies ☐Hay fever ☐Insect sting allergy

☐Latex allergy ☐Medication allergy ☐Eczema

Child's Siblings Number_____

Sibling #1 Age_____years ○Male ○Female ○Nonbinary

Mark all of the following conditions that this sibling has: ☐No allergies ☐Allergies to animals

☐Asthma ☐Food allergies ☐Hay fever ☐Insect sting allergy

☐Latex allergy ☐Medication allergy ☐Eczema

Sibling #2 Age_____years ○Male ○Female ○Nonbinary

Mark all of the following conditions that this sibling has: ☐No allergies ☐Allergies to animals

☐Asthma ☐Food allergies ☐Hay fever ☐Insect sting allergy

☐Latex allergy ☐Medication allergy ☐Eczema

Sibling #3 Age_____years ○Male ○Female ○Nonbinary

Mark all of the following conditions that this sibling has: ☐No allergies ☐Allergies to animals

☐Asthma ☐Food allergies ☐Hay fever ☐Insect sting allergy

☐Latex allergy ☐Medication allergy ☐Eczema

Sibling #4 Age_____years ○Male ○Female ○Nonbinary

Mark all of the following conditions that this sibling has: ☐No allergies ☐Allergies to animals

☐Asthma ☐Food allergies ☐Hay fever ☐Insect sting allergy

☐Latex allergy ☐Medication allergy ☐Eczema

Sibling #5 Age_____years ○Male ○Female ○Nonbinary

Mark all of the following conditions that this sibling has: ☐No allergies ☐Allergies to animals

☐Asthma ☐Food allergies ☐Hay fever ☐Insect sting allergy

☐Latex allergy ☐Medication allergy ☐Eczema

Does any family member have cystic fibrosis ○No ○Yes

Does any family member have any other type of lung disease ○No ○Yes

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 how old is the building in 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 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) _____

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? _____

Who smokes? (mark all that apply)

☐ Child (patient) ☐ Father ☐ Mother ☐ Siblings

☐ Other family members ☐ Other visitors

Do you have pets/animals? (mark all that apply)

Bird(s) how many?_____ ☐ Indoor ☐ Outdoor ☐ Indoor/Outdoor ☐ In patient's bedroom

Cat(s) how many? _____ ☐ Indoor ☐ Outdoor ☐ Indoor/Outdoor ☐ In patient's bedroom

Dog(s) how many?_____ ☐ Indoor ☐ Outdoor ☐ Indoor/Outdoor ☐ In patient's bedroom

Other (specify)

_____how many?_____ ☐ Indoor ☐ Outdoor ☐ Indoor/Outdoor ☐ In patient's bedroom

_____how many?_____ ☐ Indoor ☐ Outdoor ☐ Indoor/Outdoor ☐ In patient's bedroom

_____how many?_____ ☐ Indoor ☐ Outdoor ☐ Indoor/Outdoor ☐ In patient's bedroom

SOCIAL HISTORY

1. What grade is your child in? _____ ☐ Not applicable

2. Is your child home schooled? ○ No ○ Yes

3. Does your child attend daycare ○ No ○ Yes Hours per week? _____

How many children are in the day care? _____

4. Do you have difficulty getting your child to take medications? ○ No ○ Yes

5. Does your child have trouble making or keeping friends? ○ No ○ Yes

6. Does your child have problems in school with learning or with teachers? ○ No ○ Yes

7. Is your child in special education classes? (If yes, please bring individualized education plan) ○ No ○ Yes

8. Has your child been in counseling? ○ No ○ Yes

9. Has your child had psychological testing (If yes, please bring report) ○ No ○ Yes

10. Has your child taken any medication for any of the following reasons?

Anxiety ○ No ○ Yes

Attention deficit disorder ○ No ○ Yes

Depression ○ No ○ Yes

Hyperactivity ○ No ○ Yes

Seizures ○ No ○ Yes

Other (specify) _____

11. What are your child's hobbies/interests? _____

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 ☐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 (noisy breathing) ☐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, dry ☐Cough, wet ☐Cough at night

☐Coughing up blood ☐Frequent bronchitis/chest colds ☐Wheezing

☐Shortness of breath –day ☐Shortness of breath – night ☐Low oxygen levels

☐Shortness of breath, exercise or vigorous play ☐Other (specify)_____

GI ☐Abdominal pain/stomach ache ☐Bloody stool ☐Bloating ☐Burping

☐Choking on food/drink ☐Constipation ☐Diarrhea ☐Gassiness

☐Heartburn/acid taste ☐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 your child have any of the following?

Difficulty feeding ○ No ○ Yes Loss of appetite ○ No ○ Yes

Food avoidance ○ No ○ Yes

If yes, does your child avoid or refuse particular foods?

☐Milk ☐Egg ☐Wheat ☐Soy ☐Peanut ☐Tree nuts ☐Fish ☐Shellfish

☐Others _____

Does your child avoid certain textures or types of foods?

☐Soft/mushy texture ☐Crunchy texture ☐Bolus foods (e.g. meats/breads) ☐Spicy foods

☐Others _____

Does your child cough or choke/gag when eating or drinking?

Liquids ○No ○Yes Solids ○No ○Yes Others _____ ○No ○Yes

Genitourinary (urinary and genital organs) ☐Bedwetting ☐Wetting pants ☐Encoporesis (soiling pants)

☐Frequent urination ☐Painful urination ☐Menses (started) _____ (years old)

☐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 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

☐Not rested after sleep ☐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) _____

MEDICATIONS

Medication Name	Dose	Route	How Often	Description
Steroid Inhalers				
Aerobid (arrow-bid)				Gray w/a purple cap (mdi)
Aerobid (arrow-bid)				Light green w/a dark green cap (mdi)
Azmacort (asthma-court)				White w/a white cap 7 extension (mdi)
Asmanex				White w/a pink bottom ring 7 counter (twisthaler)
Flowvent (flow -vent)				Orange w/an orange cap (mdi)
Pulmicort (pull-mih-court)				White w/bottom brown ring in a turbuhaler or flexhaler or tube
Pulmicort (pull-mih-court)				Respules containing liquid for nebulizer
Qvar				Brown or burgundy depending on dose w/gray cap
Fast-acting Inhalers				
Albuterol (al-bew-ter-all)				White w/white cap (mdi)
Ventolin (ven-toe-lin)				Light blue w/dark blue cap & counter (mdi)
Alupent (al-you-pent)				Clear w/blue cap (mdi)
Atrovent (at-row-vent)				Clear w/green cap (mdi)
Proair (pro-air)				Red w/white cap (mdi)
Proventil (pro-vent-ill)				Yellow w/orange cap (mdi)
Maxair (max-air)				Light blue (autohaler)
Xopenex (zo-pin-ex)				Light blue w/red cap (mdi)
Combivent				Clear w/orange cap
Primatene Mist				
Long-acting Bronchodilators				
Foradil (For-A-Dill)				Blue cap covers a white tube w/a blue bottom. Insert pill into tube and pierce pill (aerolizer)
Serevent (Sara-Vent)				Green w/counter (diskus)
Spiriva (Spy-Reev-Ah)				Oval device gray base w/green piercing button. Need to load pill into oval device (handihaler)
Combination Medications (Inhaled Steroid and Long Acting Bronchodilator)				
Advair (Add-V-Air)				Purple disc w/counter (diskus)
Symbicort (Sim-By-Court)				Red w/gray cap (mdi)
Leukotriene Modifying Agents				
Singulair (Sing-Yule-Air)				Pink or tan pill
Accolate (Ac-Coal-Aid)				White pill
Zyflo (Z-Eye-Flow)				White pill (big)

Medication Name	Dose	Route	How Often	Description
Oral Steroids				
Prednisone, Deltasone, Medrol				White pill
Prelone, Pediapred, Orapred				Liquid
Other Medications				
Xolair (Zo-L-Air)				
Allergy Shots				
Intal				white w/blue cap (mdi)
Tilade				white w/white cap (mdi)
Depression, Anxiety, ADHD, Sleep				
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 _____

Clinician Signature _____ Date _____

Patient Name_____