

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

PEDIATRIC PATIENT QUESTIONNAIRE

Patient Name _____ Today's Date ____/____/____

Date of Birth ____/____/____ Age _____ Sex Male Female

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 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		Yes	No
Chicken pox	<input type="checkbox"/>	<input type="checkbox"/>	Has your child been vaccinated?	<input type="checkbox"/>	<input type="checkbox"/>
RSV	<input type="checkbox"/>	<input type="checkbox"/>			

	Yes	No	Age of Onset	Number of Times
Ear infections	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Sinus infections	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Croup	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____

Other illnesses (specify) _____

Has your child been hospitalized? No Yes

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? 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? <input type="checkbox"/> Cats <input type="checkbox"/> Dogs <input type="checkbox"/> _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is your child allergic to medications?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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)

- | | | |
|---|---|---|
| <input type="checkbox"/> No allergies | <input type="checkbox"/> Allergy to animals _____ | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Food allergy _____ | <input type="checkbox"/> Hay fever | <input type="checkbox"/> Insect sting allergy |
| <input type="checkbox"/> Latex allergy | <input type="checkbox"/> Medication allergy _____ | <input type="checkbox"/> 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)

- | | | |
|---|---|---|
| <input type="checkbox"/> No allergies | <input type="checkbox"/> Allergy to animals _____ | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Food allergy _____ | <input type="checkbox"/> Hay fever | <input type="checkbox"/> Insect sting allergy |
| <input type="checkbox"/> Latex allergy | <input type="checkbox"/> Medication allergy _____ | <input type="checkbox"/> Eczema |

Sibling 2: Age _____ years Female Male

Does he/she have any of the following conditions? (mark all that apply)

- | | | |
|---|---|---|
| <input type="checkbox"/> No allergies | <input type="checkbox"/> Allergy to animals _____ | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Food allergy _____ | <input type="checkbox"/> Hay fever | <input type="checkbox"/> Insect sting allergy |
| <input type="checkbox"/> Latex allergy | <input type="checkbox"/> Medication allergy _____ | <input type="checkbox"/> Eczema |

Sibling 3: Age _____ years Female Male

Does he/she have any of the following conditions? (mark all that apply)

- | | | |
|---|---|---|
| <input type="checkbox"/> No allergies | <input type="checkbox"/> Allergy to animals _____ | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Food allergy _____ | <input type="checkbox"/> Hay fever | <input type="checkbox"/> Insect sting allergy |
| <input type="checkbox"/> Latex allergy | <input type="checkbox"/> Medication allergy _____ | <input type="checkbox"/> 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)

- | | | |
|--|---------------------------------------|---|
| <input type="checkbox"/> Electric baseboard heat | <input type="checkbox"/> Fireplace | <input type="checkbox"/> Forced hot air (gas) |
| <input type="checkbox"/> Hot water radiator or furnace | <input type="checkbox"/> Space heater | <input type="checkbox"/> 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

<input type="checkbox"/> Pulmicort (Pull-Mih-Court)				respules containing liquid for nebulizer
<input type="checkbox"/> Qvar				brown or burgundy depending on dose w/gray cap

Medication Name	Dose	Route	How Often	Description
Fast-acting Inhalers				
<input type="checkbox"/> Albuterol (Al-Bew-Ter-All)				white w/white cap (mdi)
<input type="checkbox"/> Ventolin (Ven-Toe-Lin)				light blue w/dark blue cap & counter (mdi)
<input type="checkbox"/> Alupent (Al-You-Pent)				clear w/blue cap (mdi)
<input type="checkbox"/> Atrovent (At-Row-Vent)				clear w/green cap (mdi)
<input type="checkbox"/> Proair (Pro-Air)				red w/white cap (mdi)
<input type="checkbox"/> Proventil (Pro-Vent-III)				yellow w/orange cap (mdi)
<input type="checkbox"/> Maxair (Max-Air)				light blue (autohaler)
<input type="checkbox"/> Xopenex (Zo-Pin-Ex)				light blue w/red cap (mdi)
<input type="checkbox"/> Combivent				clear w/orange cap
<input type="checkbox"/> Primatene Mist				
Long-acting Bronchodilators				
<input type="checkbox"/> Foradil (For-A-Dill)				blue cap covers a white tube w/a blue bottom. Insert pill into tube and pierce pill (aerolizer)
<input type="checkbox"/> Serevent (Sara-Vent)				green w/counter (diskus)
<input type="checkbox"/> 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)				
<input type="checkbox"/> Advair (Add-V-Air)				purple disc w/counter (diskus)
<input type="checkbox"/> Symbicort (Sim-By-Court)				red w/gray cap (mdi)
Leukotriene Modifying Agents				
<input type="checkbox"/> Singulair (Sing-Yule-Air)				pink or tan pill
<input type="checkbox"/> Accolate (Ac-Coal-Aid)				white pill
<input type="checkbox"/> Zflo (Z-Eye-Flow)				white pill (big)
Oral Steroids				
<input type="checkbox"/> Prednisone, Deltasone, Medrol				white pill
<input type="checkbox"/> Prelone, Pediapred, Orapred				liquid
Other Medications				
<input type="checkbox"/> Xolair (Zo-L-Air)				
<input type="checkbox"/> Allergy Shots				
<input type="checkbox"/> Intal				white w/blue cap (mdi)

<input type="checkbox"/> Tilade				white w/white cap (mdi)

Medication Name	Dose	Route	How Often	Description
Antihistamines				
<input type="checkbox"/> Allegra				
<input type="checkbox"/> Benadryl				
<input type="checkbox"/> Hydroxyzine				
<input type="checkbox"/> Clarinex				
<input type="checkbox"/> Claritin				
<input type="checkbox"/> Xyzal				
<input type="checkbox"/> Zyrtec				
Nose Spray				
<input type="checkbox"/> Saline				
<input type="checkbox"/> Astelin				
<input type="checkbox"/> Flonase				
<input type="checkbox"/> Nasacort AQ				
<input type="checkbox"/> Nasonex				
<input type="checkbox"/> Rhinocort AQ				
<input type="checkbox"/> Veramyst				
<input type="checkbox"/> Zantac/Ranitidine				
<input type="checkbox"/> Proton pump inhibitors				
<input type="checkbox"/> Epipen				
<input type="checkbox"/> Ointments				
<input type="checkbox"/> Others				

Parent Signature

Date

Clinician Signature

Date