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 comprehensive program where you and your family will join a dedicated multidisciplinary team, working together to provide the best individualized care for your child. The team will include a medical attending physician, a physician in-training in allergy/immunology or an experienced physician's assistant, registered nurses, child life specialist, and a behavioral health specialist. Behavioral health clinicians are a part of the Pediatric Day Program team to help our patients and their families cope with the stresses associated with managing chronic diseases. Other medical providers such as gastroenterologists, pulmonologists as well as dieticians and sleep specialists may be consulted depending on your child’s needs.

Our unique program enables the team to observe and monitor your child’s symptoms throughout the day, which facilitates making an accurate diagnosis and developing a successful individualized treatment plan. You will have a “home base” within the Pediatric Care Unit where you check in each day and review your daily schedule with the physicians and nurses. During your stay, you and your child will attend medical appointments, have necessary tests performed, and actively participate in disease management education classes and groups.

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 that you may find helpful in preparing 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.
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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 off the National Jewish Health campus, call the pediatric Triage area, 303-398-1239, where your child can receive immediate care. Please alert the nurses that your child is here for the Day Program. If your child is having significant breathing problems or other emergent conditions, call 911.

Arrival Time - Families should arrive at the time given to them by their Patient Administrative Coordinator, and report to the Department of Pediatrics at our main campus location. Should your arrival time be delayed, please call 303-398-1239.

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

Length of Stay - The average length of stay is ten business days, but can be longer or shorter depending on your child’s illness and his/her diagnostic needs.

Where to Stay - Day Program patients and one parent/guardian need to stay overnight in the hospital on the day of admission. During your time at National Jewish Health lodging and transportation is the responsibility of your family to arrange. Please visit the National Jewish website, www.njhealth.org for a list of local hotels and non-profit facilities that offer special discounted rates to National Jewish patients.

Where To Be During The Day - Our patient census varies day to day, therefore there may not always be a private room for you and your child, but you will have access to the common areas on the unit. We will however try to accommodate your needs to the best of our capability. You will be provided with a locker to store your belongings/valuables.

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

**Meals**- Breakfast and lunch are provided for patients Monday through Friday. 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.

**Parking**- There is free patient parking available Monday-Sunday 24 hours a day. We also offer valet services to our patients and visitors free of charge 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. However, it is the patient’s responsibility to verify prescription benefits with their insurance carriers; and 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. The pharmacy hours are Monday-Friday 8:30 a.m. to 6:00 p.m.

**Laundry and Linen**- You will have access to a washing machine and a dryer on the unit. It is essential that you mark your child’s clothing and personal items with his/her full name. Please make sure you understand the operation of the machines (instructions are printed on the sides), and use only unscented, non-enzyme detergents.

**Patients Representative Program**- A Patient Representative Program is available to assist patients and families with special concerns that are not resolved by members of the patient’s care team. You may contact the Patient Representative by calling (303) 398-1076, or by dialing the in-house operator.
Responsibilities as a Parent and Patient

• Please do not wear perfumes, colognes, aftershave, scented lotions, or scented hair products, as these can cause an allergic reaction in some of our patients.

• National Jewish Health is a Non-Smoking Facility

• Please be sure you are 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. Please notify your Patient Administrative Coordinator at (303)-398-1239 advance if you cannot keep an appointment.

• Please make sure all medical records are sent to National Jewish Health in advance of your visit. Please see the Medical Records section for further direction.

• Please complete the attached patient questionnaire and return it to your Patient Administrative Coordinator.

• Please ensure you follow the guidelines found within 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 will help your medical team complete a relevant and useful treatment plan for your child.

• Know the names and dosages of the medications your child is taking. Please 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.

• Please understand that 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. If you have questions about your coverage please contact your insurance carrier.

• Your child may require testing at another healthcare facility. The staff will assist you in making these arrangements. However, please note that 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.
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.

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**Eczema Patients Only:**
- [ ] 6 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

*For examples please visit our website njhealth.com

**If your child uses any of the following please also bring:**
- [ ] 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
Items to Bring for Day Program continued

12 pairs long cotton tube socks

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

3+ sets of long underwear or cotton footie pajamas
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 Allergy Testing. This test 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 as they can affect the results.** Check with your child’s doctor before you stop any medicines.

- Withhold oral antihistamines for the designated length of time before your appointment.

  - Withhold these oral antihistamines for **5-days** prior to your appointment:
    - Claritin® (Loratadine), Allegra® (Fexofenadine), Clarinex® (Desloratadine)

  - Withhold these oral antihistamines for **3 - 4 days** prior to your appointment:
    - Actifed®, Dimetapp® (Brompheniramine)
    - Atarax®, Vistaril® (Hydroxyzine)
    - Benadryl® (Diphenhydramine)
    - Chlortrimeton® (Chlorpheniramine)
    - Phenergan® (Promethazine)
    - Tavist®, Antihist® (Clemastine)
    - Actifed®, Aller-Chlor®, Bromfed®, (Combination medicines)
    - Drixoral®, Dura-tab®, Novafed-A®, (Cetirizinei)
    - Onrade®, Poly-Histine-D®, Trinalin®
    - Zyrtec®

  - Withhold 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 take all other medicine as your child usually does.
Patient Financial Responsibility

National Jewish Health is committed to providing quality healthcare 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 co-payments, deductible, and/or co-insurance 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 the medical services scheduled 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 co-payment/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 co-payments for prescriptions will be collected at the Pharmacy.
How to Request Medical Records

If you want your medical records mailed to National Jewish Health, please comply with 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

**Patient Information**

<table>
<thead>
<tr>
<th>Full Name</th>
<th>Medical Record #</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address</td>
<td></td>
</tr>
<tr>
<td>City</td>
<td>State</td>
</tr>
<tr>
<td>Phone #</td>
<td>Date of Birth</td>
</tr>
</tbody>
</table>

**I hereby authorize:**

- National Jewish Health - Main Campus 1400 Jackson St Denver, CO 80206 PH (303) 398-1580 FAX (303) 398-1211
- NJH - Highlands Ranch 8671 S. Quebec St. Ste 120 Highlands Ranch, CO 80130 PH (303) 703-3646 FAX (303) 738-1385
- NJH - South Denver 499 E. Hampden Ave. Ste 300 Englewood, CO 80113 PH (303) 788-8500 FAX (303) 788-8505
- Other:
  - Name/Title Organization
  - Address
  - City/State/Zip Phone Fax

**Release To:**

- National Jewish Health - Main Campus 1400 Jackson St Denver, CO 80206 PH (303) 398-1580 FAX (303) 398-1211
- NJH - Highlands Ranch 8671 S. Quebec St. Ste 120 Highlands Ranch, CO 80130 PH (303) 703-3646 FAX (303) 738-1385
- NJH - South Denver 499 E. Hampden Ave. Ste 300 Englewood, CO 80113 PH (303) 788-8500 FAX (303) 788-8505
- Other:
  - Name/Title Organization
  - Address
  - City/State/Zip Phone Fax

**Purpose & PHI Disclosed**

- Continuation of Care
- Insurance
- Legal
- Personal Use
- Other

For Treatment Date(s)

- Clinic Summary/Consultation
- Procedure
- Laboratory/Radiology
- Pulmonary Test
- Cardiology Test
- Other

**Fees**

<table>
<thead>
<tr>
<th>Pages</th>
<th>Patient</th>
<th>Others</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-10</td>
<td>$14.00</td>
<td>$16.50</td>
</tr>
<tr>
<td>11-40</td>
<td>.50 each</td>
<td>.75 each</td>
</tr>
<tr>
<td>41+</td>
<td>.33 each</td>
<td>.50 each</td>
</tr>
</tbody>
</table>

According to Colorado State Statute, 6 C.C.R. 1011-1, Chapter 2 Part 5.2.3.4 the following fees may be charged for copies of medical records. Records will be provided to other health care providers at no charge.

**Authorization**

- 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 my 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.

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 redisclosure by the recipient and is no longer protected by the HIPAA privacy rule.

Without my express revocation, this consent will automatically expire 180 days from the date signed below, unless I request an expiration date less than 180 days.

**Signature**

My signature is required to validate this Authorization. If I sign this form, my health care, the payment for my health care or my ability to enroll for benefits will not be affected.

| Patient or Authorized Representative Signature | Date | Relationship |
Main National Jewish Health Campus
1400 Jackson Street
Denver, Colorado 80206

National Jewish Health
South Denver
499 East Hampden Avenue, Suite 300
Englewood, Colorado 80113

National Jewish Health
at Highlands Ranch
8671 South Quebec Street, Suite 120
Highlands Ranch, Colorado 80130

National Jewish Health
Sleep Center at Broomfield
TownePlace Suites by Marriott
480 Flatiron Boulevard, Suite 120
Broomfield, Colorado 80021

National Jewish Health
Sleep Center at Denver Tech Center
TownePlace Suites by Marriott
7877 South Chester Street
Englewood, Colorado 80112
National Jewish Health Clinic Locations

NATIONAL JEWISH HEALTH MAIN CAMPUS
1400 Jackson Street
Denver, CO 80206
njhealth.org

SLEEP CENTER AT DENVER TECH CENTER
National Jewish Health
Sleep Center at Denver Tech Center
TownPlace Suites by Marriott
7877 Chester Street
Englewood, CO 80112

NATIONAL JEWISH HEALTH AT HIGHLANDS RANCH
8671 South Quebec Street, Suite 120
Highlands Ranch, CO 80130
Referring Physician Information

In order to provide results and recommendations from your child’s evaluation at National Jewish, 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: _____________________________________________________________________________
City________________________ State________ Zip __________
Telephone:____________________ Fax:_____________________________________________________

**Specialist Physician** (Last, First): ______________________________________________________
Address: _____________________________________________________________________________
City________________________ State________ Zip __________
Telephone:____________________ Fax:_____________________________________________________

**Specialist Physician** (Last, First): ______________________________________________________
Address: _____________________________________________________________________________
City________________________ State________ Zip __________
Telephone:____________________ Fax:_____________________________________________________

**Specialist Physician** (Last, First): ______________________________________________________
Address: _____________________________________________________________________________
City________________________ State________ Zip __________
Telephone:____________________ Fax:_____________________________________________________

I authorize National Jewish Health to release medical information to the above physicians.

**Patient/Parent**
Signature: ____________________________________________________________________________
PATIENT NAME: ___________________________________________________  ADM 164 (4/12)

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___________________________________________  Referring Physician #2

Address__________________________________________________________________________

Phone__________________________________________________________________________
Fax__________________________________________________________________________
Email__________________________________________________________________________

Referring Physician #3

Name___________________________________________  PHARMACY INFORMATION

Address__________________________________________________________________________

Phone__________________________________________________________________________
Fax__________________________________________________________________________
Email__________________________________________________________________________

Mail Order Pharmacy

Name___________________________________________  Alternate Pharmacy

Address__________________________________________________________________________

Phone__________________________________________________________________________
Fax__________________________________________________________________________

Local Pharmacy

Name___________________________________________

Address__________________________________________________________________________

Phone__________________________________________________________________________
Fax__________________________________________________________________________
Email__________________________________________________________________________
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?

Has your child been vaccinated? □ Yes □ No

<table>
<thead>
<tr>
<th>Disease</th>
<th>Yes</th>
<th>No</th>
<th>Age of Onset</th>
<th>Number of Times</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chicken pox</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>RSV</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ear infections</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sinus infections</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pneumonia</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Croup</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other illnesses</td>
<td>□</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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) ______________________________

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

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

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

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

7. Is your child in special education classes?  □  Yes   □  No

   If Yes, please bring individualized education plan.

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

9. Has your child had psychological testing?  □  Yes   □  No

   If Yes, please bring report.

10. Has your child taken any medication for any of the following reasons?  Yes  No

    Anxiety □  □

    Attention deficit disorder (ADD) □  □

    Depression □  □

    Hyperactivity □  □

    Seizures □  □

    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 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: ____________________________

Genitourinary
- □ Bedwetting
- □ Wetting pants
- □ Encoporesis (soiling 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 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) ______________________

MEDICATIONS
What medications does your child take?

<table>
<thead>
<tr>
<th>Medication Name</th>
<th>Dose</th>
<th>Route</th>
<th>How Often</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Steroid Inhalers</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Aerobid (Arrow-Bid)</td>
<td></td>
<td>gray w/a purple cap (mdi)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Aerobid (Arrow-Bid)</td>
<td></td>
<td>light green w/a dark green cap (mdi)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Azmacort (Asthma-Court)</td>
<td></td>
<td>white w/a white cap 7 extension (mdi)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Asmanex</td>
<td></td>
<td>white w/a pink bottom ring 7 counter (twisthaler)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Flovent (Flow-Vent)</td>
<td></td>
<td>orange w/an orange cap (mdi)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Pulmicort (Pull-Mih-Court)</td>
<td></td>
<td>white w/bottom brown ring in a turbulhaler or flexhaler or tube</td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Pulmicort (Pull-Mih-Court)</td>
<td></td>
<td>respules containing liquid for nebulizer</td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Qvar</td>
<td></td>
<td>brown or burgundy depending on dose w/gray cap</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medication Name</td>
<td>Dose</td>
<td>Route</td>
<td>How Often</td>
<td>Description</td>
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<tr>
<td><strong>Fast-acting Inhalers</strong></td>
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<tr>
<td>☐ Albuterol (Al-Bew-Ter-All)</td>
<td></td>
<td></td>
<td></td>
<td>white w/white cap (mdi)</td>
</tr>
<tr>
<td>☐ Ventolin (Ven-Toe-Lin)</td>
<td></td>
<td></td>
<td></td>
<td>light blue w/dark blue cap &amp; counter (mdi)</td>
</tr>
<tr>
<td>☐ Alupent (Al-You-Pent)</td>
<td></td>
<td></td>
<td></td>
<td>clear w/blue cap (mdi)</td>
</tr>
<tr>
<td>☐ Atrovent (At-Row-Vent)</td>
<td></td>
<td></td>
<td></td>
<td>clear w/green cap (mdi)</td>
</tr>
<tr>
<td>☐ Proair (Pro-Air)</td>
<td></td>
<td></td>
<td></td>
<td>red w/white cap (mdi)</td>
</tr>
<tr>
<td>☐ Proventil (Pro-Vent-III)</td>
<td></td>
<td></td>
<td></td>
<td>yellow w/orange cap (mdi)</td>
</tr>
<tr>
<td>☐ Maxair (Max-Air)</td>
<td></td>
<td></td>
<td></td>
<td>light blue (autohaler)</td>
</tr>
<tr>
<td>☐ Xopenex (Zo-Pin-Ex)</td>
<td></td>
<td></td>
<td></td>
<td>light blue w/red cap (mdi)</td>
</tr>
<tr>
<td>☐ Combivent</td>
<td></td>
<td></td>
<td></td>
<td>clear w/orange cap</td>
</tr>
<tr>
<td>☐ Primatene Mist</td>
<td></td>
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</tr>
<tr>
<td><strong>Long-acting Bronchodilators</strong></td>
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<tr>
<td>☐ Foradil (For-A-Dill)</td>
<td></td>
<td></td>
<td></td>
<td>blue cap covers a white tube w/a blue bottom. Insert pill into tube and pierce pill (aerolizer)</td>
</tr>
<tr>
<td>☐ Serevent (Sara-Vent)</td>
<td></td>
<td></td>
<td></td>
<td>green w/counter (diskus)</td>
</tr>
<tr>
<td>☐ Spiriva (Spy-Reev-Ah)</td>
<td></td>
<td></td>
<td></td>
<td>oval device gray base w/green piercing button. Need to load pill into oval device (handihaler)</td>
</tr>
<tr>
<td><strong>Combination Medications (Inhaled Steroid and Long Acting Bronchodilator)</strong></td>
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<tr>
<td>☐ Advair (Add-V-Air)</td>
<td></td>
<td></td>
<td></td>
<td>purple disc w/counter (diskus)</td>
</tr>
<tr>
<td>☐ Symbicort (Sim-By-Court)</td>
<td></td>
<td></td>
<td></td>
<td>red w/gray cap (mdi)</td>
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<tr>
<td><strong>Leukotriene Modifying Agents</strong></td>
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<tr>
<td>☐ Singulair (Sing-Yule-Air)</td>
<td></td>
<td></td>
<td></td>
<td>pink or tan pill</td>
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<tr>
<td>☐ Accolate (Ac-Coal-Aid)</td>
<td></td>
<td></td>
<td></td>
<td>white pill</td>
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<tr>
<td>☐ Zyflo (Z-Eye-Flow)</td>
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<td></td>
<td>white pill (big)</td>
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<tr>
<td><strong>Oral Steroids</strong></td>
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<tr>
<td>☐ Prednisone, Deltasone, Medrol</td>
<td></td>
<td></td>
<td></td>
<td>white pill</td>
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<tr>
<td>☐ Prelone, Pediapred, Orapred</td>
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<td></td>
<td>liquid</td>
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<tr>
<td><strong>Other Medications</strong></td>
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<tr>
<td>☐ Xolair (Zo-L-Air)</td>
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<tr>
<td>☐ Allergy Shots</td>
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<tr>
<td>☐ Intal</td>
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<td></td>
<td>white w/blue cap (mdi)</td>
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<tr>
<td>☐ Tilade</td>
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<td></td>
<td>white w/white cap (mdi)</td>
</tr>
<tr>
<td>Medication Name</td>
<td>Dose</td>
<td>Route</td>
<td>How Often</td>
<td>Description</td>
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<tr>
<td><strong>Antihistamines</strong></td>
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<tr>
<td>☐ Allegra</td>
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<tr>
<td>☐ Benadryl</td>
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<tr>
<td>☐ Hydroxyzine</td>
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<tr>
<td>☐ Clarinex</td>
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<tr>
<td>☐ Claritin</td>
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<tr>
<td>☐ Xyzal</td>
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<tr>
<td>☐ Zyrtec</td>
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<tr>
<td><strong>Nose Spray</strong></td>
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<tr>
<td>☐ Saline</td>
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<tr>
<td>☐ Astelin</td>
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<tr>
<td>☐ Flonase</td>
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<tr>
<td>☐ Nasacort AQ</td>
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<tr>
<td>☐ Nasonex</td>
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<tr>
<td>☐ Rhinocort AQ</td>
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<tr>
<td>☐ Veramyst</td>
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<tr>
<td>☐ Zantac/Ranitidine</td>
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<tr>
<td>☐ Proton pump inhibitors</td>
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<tr>
<td>☐ Epipen</td>
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<tr>
<td>☐ Ointments</td>
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<tr>
<td>☐ Others</td>
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</tr>
</tbody>
</table>

Parent Signature ___________________________ Date ________________

Clinician Signature ________________________ Date ________________
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