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Patient Name:

PEDIATRIC PULMONOLOGY NEW PATIENT INTAKE FORM – GENERAL

Department of Pediatric Pulmonology & Sleep Medicine

Before your visit, please answer these questions to help the doctor understand your child's medical history. This will help the doctor spend more time talking about the main reason for your visit. It is "ok" to leave any question(s) blank if you do not feel comfortable answering.

1. General pediatrician: _____
2. Is the person filling out this form someone other than a biological parent? ☐ Yes ☐ No

   If yes, b) what is the relationship to the child? _____
3. Please briefly describe why you're seeking a pediatric pulmonary consultation for your child:

_____

_____

_____

_____

_____

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Communicate with your child's doctor about his/her breathing symptoms

Please choose one answer for each of the following questions. This will help your doctor give you the best care. Questions 1-6 ask about how your child's symptoms have been over the past 12 months, not just today. If your child has had symptoms for less than 12 months, then think about how things have been since he/she started having respiratory (breathing) symptoms.

Over the past 12 months:	**Direction**		
1) How have your child's symptoms been?	Better	Same	Worse
List specific breathing symptoms:	☐	☐	☐
Over the past 12 months:	**Bothered**		
2) How much have you been bothered by your child's breathing symptoms?	Not	Somewhat	Very
	☐	☐	☐

Over the past 12 months (BEFORE TODAY):	**Risk**				
	0	1	2	3	≥4
3) How many times has your child been to **urgent care** for breathing-related issues over the last 12 months?	☐	☐	☐	☐	☐
4) How many times has your child been to the **emergency room** for breathing issues over the last 12 last months?	☐	☐	☐	☐	☐
5) How many times your child **hospitalized** for breathing issues over the last 12 months?	☐	☐	☐	☐	☐
6) How many times has your child used an **oral steroid** (Orapred, steroid pill, steroid liquid or syrup) for breathing issues over the last 12 months? **Don't include today.**	☐	☐	☐	☐	☐

Take Medicine	My child is not supposed to take a daily breathing medicine	All of the time 5-7 days/ week	Most of the time 3-4 days/ week	Some of the time 1-2 days/ week	None of the time
7) How often do you give your child **daily** breathing medicine when he/she feels fine? Daily medicines include: Advair, Alvesco, Asmanex, Budesonide, Dulera, Flovent, QVAR, Pulmicort, Singulair, Symbicort, etc.	☐	☐	☐	☐	☐

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Sub-Acute Symptoms – These questions are about your child's **recent** breathing symptoms.

Current Breathing Symptoms	**Days**				
8) Over the **past week**, how many days has your child had breathing symptoms? e.g., *Cough *Tight chest *Short of breath *Sputum (spit, mucus, phlegm with cough) *Difficulty taking a deep breath *Wheezy or whistling sound in the chest	0	1-2	3-6	Every Day (not all day long)	Every Day (all day Long)
	☐	☐	☐	☐	☐
Reliever Use					
9) Over the **past week** how many days have you had to give your child medicine to quickly relieve breathing symptoms (e.g., Albuterol, Proventil, ProAir, Ventolin, Xopenex)	☐	☐	☐	☐	☐

Attacks	**Days**			
	0	**1**	**2-3**	**4-7**
10) Over the **past week**, how many days did your child have a breathing "attack"? (e.g. *Hard to breathe *Gave more quick-relief medicine (e.g., Albuterol) *Breathing medicine did not work	☐	☐	☐	☐

Activity Limitation	None	Slightly	Moderately	Very	Completely
11) Over the **past week** how much has breathing symptoms limited your child's activities?	☐	☐	☐	☐	☐
Night Symptoms	0	1	2	3-7	8-14
12) Over the past **TWO WEEKS**, how many nights did your child's breathing symptoms keep your child from sleeping or woke him/her up?	☐	☐	☐	☐	☐

13) Please list concerns or anything else you would like your doctor know about your child's breathing symptoms.

FOR CLINICIAN USE ONLY **CONTROL/SEVERITY ASSIGNMENT:** Assign current level of control by box checked farthest to the right on questions 8-12 and match box color to the level of control in this selection.	**Sub-Acute Severity/Control Classification**			
	☐	☐	☐	☐
	Controlled/ Intermittent	Partially Controlled/ Mild Persistent	Uncontrolled/ Moderate	Poorly Controlled/ Severe

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PAST MEDICAL HISTORY

Medical History (General)

Has your child had any of the following medical problems/ If so, please specify next to each medical problem at what age it was first noted (mark all that apply):

	Age		Age
☐ Eczema		☐ Snoring/sleep apnea	
☐ Failed hearing screen		☐ Swallowing issues	
☐ Gastroesophageal reflux		☐ Don't know	
☐ Heart problems		☐ None of these	
☐ Poor weight gain		☐ Other problems (describe below)	

If applicable, please describe other problems and specify when it was diagnosed:

_____

_____

Surgical History

Has your child ever had surgery? ☐ No ☐ Don't know ☐ Yes

If Yes – check all that apply and write the approximate date of surgery:

	Date of Surgery		Date of Surgery
☐ Adenoidectomy		☐ Tonsillectomy	
☐ Cleft palate/lip		☐ Tracheostomy	
☐ Feeding tube		☐ Tympanostomy/PE tubes	
☐ Nissen fundoplication		☐ VP Shut	
☐ Sinus surgery		☐ Other type of surgery, describe below:	
☐ Spine			

Family Medical History

Please indicate medical history of family members. If "other" please specify the diagnosis in the column marked "other".

	Don't know	Seasonal Allergies/hayfever	Eczema	Asthma	Other
Biological mother	☐	☐	☐	☐	☐
Biological father	☐	☐	☐	☐	☐
Brother	☐	☐	☐	☐	☐
Sister	☐	☐	☐	☐	☐
Other member: Who?	☐	☐	☐	☐	☐
Other member: Who:	☐	☐	☐	☐	☐

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SOCIODEMOGRAPHICS

People living with child

1. What is your relationship to the child?

☐ Biological mother	☐ Adoptive mother
☐ Biological father	☐ Adoptive father
☐ Grandmother	☐ Legal guardian
☐ Grandfather	☐ Other, please specify:

2. What is your marital status?

☐ Married	☐ Widowed
☐ Separated	☐ Single, living with significant other
☐ Divorced	☐ Single, not living with significant other

Are you married to the biological parent of this child? ☐ No ☐ Yes

3. Is there another primary caregiver in the home? ☐ No ☐ Yes
   If yes, what is his/her relationship to the child?

☐ Biological mother	☐ Adoptive mother
☐ Biological father	☐ Adoptive father
☐ Grandmother	☐ Legal guardian
☐ Grandfather	☐ Other, please specify:

4. Is there another primary caregiver that splits time (custody) caring for the patient whom does not live in your home? ☐ No ☐ Yes – If yes, what is his/her relationship to the child?

☐ Biological mother	☐ Adoptive mother
☐ Biological father	☐ Adoptive father
☐ Grandmother	☐ Legal guardian
☐ Grandfather	☐ Other, please specify:

What percent of the time does your child live with him/her? _____

5. Does the patient have siblings? ☐ No ☐ Yes
   If yes, please list the 1) age or birthdate 2) Gender (M/F/Other) 3) If they live with the patient (Y/N)

Age or Birthdate	Gender	Live with patient
	☐ M ☐ F ☐ Other	☐ No ☐ Yes
	☐ M ☐ F ☐ Other	☐ No ☐ Yes
	☐ M ☐ F ☐ Other	☐ No ☐ Yes
	☐ M ☐ F ☐ Other	☐ No ☐ Yes
	☐ M ☐ F ☐ Other	☐ No ☐ Yes
	☐ M ☐ F ☐ Other	☐ No ☐ Yes

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Child's Education

1. Is your child attending school, preschool or daycare? _____
2. What grade is your child in now? _____
3. What school? _____
4. How are his/her grades? _____
5. Are there any behavior or attention problems at school? ☐ No ☐ Yes

   If yes, when did they start? _____

Parental Education/Work

1. Please indicate the highest level of education COMPLETED:

	You	Other caregiver w/parent custody
Less than high school	☐	☐
High school graduate	☐	☐
2- year college or technical school	☐	☐
4-year college graduate	☐	☐
Any post-graduate study	☐	☐
Don't know	☐	☐

2. Please indicate the current work situation of you and your child's other caregiver:

	You	Other caregiver w/parent custody
Working at a paying full-time job	☐ Occupation:	☐ Occupation:
Working at a paying part-time job	☐ Occupation:	☐ Occupation:
Not working, but looking for a paying job	☐	☐
Disabled	☐	☐
Retired	☐	☐
Full-time homemaker	☐	☐
Working at a temp job/day	☐	☐

Language/Ethnicity

1. In general, what language(s) does your family speak at home?

☐ English only	☐ Spanish more than English
☐ Spanish only	☐ English and another language:
☐ English more than Spanish	☐ Only another language (specify):
☐ Both Spanish and English	

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2. How would you describe the ethnicity of this child and his/her biological parents?

Please check all that apply:	Child	Biological mother	Biological father
White/Caucasian	☐	☐	☐
Black/African American	☐	☐	☐
Black, not African American	☐	☐	☐
Hispanic/Latino (specify):	☐	☐	☐
Native United State of America/Alaska	☐	☐	☐
Asian/Asian American (specify):	☐	☐	☐
Pacific Islander/Native Hawaiian	☐	☐	☐
Other race/ethnicity (specify):	☐	☐	☐
Don't know	☐	☐	☐

3. How long have you lived in the United States? ☐ All my life or _____ years
   If not all of your life, what is your country of origin? _____

Home Environment

1. Is your home (check one of the following):

☐ Apartment	☐ Row house	☐ Single family house	☐ Townhouse
☐ Mobile home	☐ Other:		

If child split time between household, what type of home is it? _____

2. Does your home have (check all that apply):

☐ Birds	☐ Damp areas	☐ Plants
☐ Cat(s)/how many?	☐ Dog(s)/how many?	☐ Radiator heating
☐ Central air conditioning	☐ Hot tub/Jacuzzi	☐ Window air conditioning unit
☐ Central or forced warm air heating	☐ Humidifier	☐ Wood stove
	☐ Mice (not pets)	☐ None of these
☐ Cockroaches		

If child splits time between households, does the other home have any of the above?
☐ No ☐ Yes – If yes, please list: _____

3. Does your child's bedroom have (check all that apply):

☐ Area rugs	☐ Stuff toys	☐ None of these
☐ Hardwood floors	☐ Wall-to-wall carpet	

If child splits time between households, does the other home have any of the above?
☐ No ☐ Yes – If yes, please list: _____

4. Does your child use (check all that apply):

☐ Dust mite-proof pillow covers	☐ Dust mite-proof bed covers	☐ None of these

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If child splits time between households, does the other home have any of the above?
☐ No ☐ Yes – If yes, please list: _____

5. How is cigarette smoking handled as far as your home is concerned?

☐ Smoking is not allowed inside or outside the home
☐ Smoke is allowed outside the home
☐ Smoking is sometimes allowed in the home
☐ Smoking is always allowed in the home

Please indicate smoking status of each of the following people/places your child may be present:

	Mother(or person w/primary custody)	Father (or person w/primary custody)	Any other relative (e.g., aunt, uncle, grandparent sig other, etc.)	Daycare provider
Is this person a CURRENT SMOKER?	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes

How much effect do you think tobacco smoke exposure has on your child's breathing symptoms?

☐ No bad effect	☐ A moderate bad effect
☐ A small bad effect	☐ A large bad effect

BIRTH HISTORY

1. What city, state and hospital was your child born?

City	State	Hospital

2. Did the child's mother use any of the below? Check all that apply:

☐ Early labor (before 37 weeks)	☐ High blood sugar or diabetes	☐ None of these
☐ High blood pressure	☐ Infection	☐ Don't know

3. Did the child's mother use any of the below? Check all that apply:

☐ Alcohol	☐ Cigarettes	☐ Drugs (methadone, cocaine, marijuana)
☐ Other:	☐ None of these	☐ Don't know

4. After how many weeks of pregnancy was your child born?

_____ Weeks	☐ Not sure, probably on time (37-40 weeks)	☐ Not sure premature (36 weeks or less)

5. How was this child born?

☐ Vaginal delivery	☐ Cesarean section	☐ Don't know

6. Was your child conceived with in vitro fertilization (IVF) technology? ☐ No ☐ Yes

7. How much did your child weigh when he/she was born? Please write in pound/ounces or grams:

_____pounds _____ounces	_____grams	☐ Don't know

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8. What is the birth order of this child? How many total children? _____

☐ 1st	☐ 2nd	☐ 3rd	☐ Other	☐ Don't know

9. How long did this child stay in the hospital before going home?

☐ Less than 48 hours	☐ More than 48 hours	☐ Don't know

10. Did your child need help from a breathing machine (e.g., respiratory, CPAP) after he/she was born?

☐ No	☐ Yes, for how many days, weeks or months? _____ days _____weeks or _____ months	☐ Don't know

If yes, what type of breathing machine?

☐ CPAP	☐ Nasal SIMV/SiPAP/BiPAP	☐ Ventilator/respirator
☐ Don't know	☐ Other:	

11. Did your child require oxygen when born?

☐ No	☐ Yes, for how many days, weeks or months? _____ days _____weeks or _____ months	☐ Don't know

12. Did your child require oxygen when discharged from the hospital?

☐ No	☐ Yes, for how many days, weeks or months? _____ days _____weeks or _____ months	☐ Don't know

13. Did this child breast-feed? ☐ No ☐ Don't know ☐ Yes – for how many months? _____

OTHER HISTORY

Breathing Symptoms History

1. Has your child ever spent the night in a hospital to be treated for breathing issues (e.g., RSV, bronchiolitis, asthma, low oxygen levels, pneumonia)?

☐ No	☐ Yes – how many times? _____ time(s)	☐ Don't know

If yes, please list dates, length of stay and diagnosis (if you have this information):

Date(s)	Length of Stay	Diagnosis

How many of the hospitalizations required the intensive care unit (ICU)? _____

How many of the hospitalizations did your child need a breathing tube? _____

2. Has your child ever taken a steroid by mouth (for example: Prednisone, Prelone, Orapred) to treat a breathing problem?

☐ No	☐ Yes, how many time(s)? _____ time(s)	☐ Don't know

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3. Has your child's chest ever sounded wheezy or whistling?

☐ No	☐ Yes	☐ Don't know

If yes, how frequently do you or did you hear this sound?

☐ Very rarely	☐ Some days of the week	☐ On most days of the week
☐ Few days of the week	☐ Many days of the week	

If yes, did you hear this wheezing or whistling sound before/ he/she was 4 years old?

☐ No	☐ Yes	☐ Not applicable (child is less than 4 years)	☐ Don't know

4. Has your child ever been diagnosed with asthma?

☐ No	☐ Yes – at what age?_____	☐ Don't know

5. What triggers your child's breathing symptoms (e.g., wheeze, cough)? Check all that apply:

☐ Allergy/hay fever	☐ Colds/respiratory viruses	☐ Grass	☐ Tobacco smoke
☐ Aspirin/ibuprofen		☐ Mold	☐ Trees
☐ Cats	☐ Dogs	☐ Season: Fall	☐ Don't know
☐ Changes in season	☐ Dust	☐ Season: Spring	☐ None of the above
☐ Changes in weather	☐ Exercise	☐ Season: Summer	☐ Other:
☐ Cold air	☐ Fumes or perfumes	☐ Season: Winter	

6. How much school (or daycare) is missed from breathing issues (e.g., wheeze, cough, noise)?

☐ Never	☐ Less than 5 days per year
☐ My child is not in school or daycare	☐ Don't know

Allergies

1. Has your child been previously tested for any form of allergy? ☐ No ☐ Yes
   If yes, was it blood testing, skin testing or both? _____
   If the allergy test did not show any allergies, check here ☐
   If the allergy test did not show allergies, what are they? Check all that apply:

Environmental Allergies:

☐ Cat	☐ Grass	☐ Weeds
☐ Cockroach	☐ Latex	☐ Ragweed
☐ Dog	☐ Mold	☐ Trees
☐ Dust mite	☐ Mouse	☐ Other positive (describe below)

Food Allergies:

☐ Eggs	☐ Milk Products
☐ Peanuts	☐ Other positive (describe below)

2. **Allergy to medication?** ☐ No ☐ Yes – if yes, please specify medication(s) and reaction:

Medication	Reaction

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Immunizations

Child is up to date on routine vaccines? ☐ No ☐ Yes

Child up to date on yearly influenza vaccine? ☐ No ☐ Yes

Development

How old was your baby when he/she first did the following?

Sat on own:	Said first words:	Walked:
Put 2 or 3 words together:	☐ None applicable	

REVIEW OF SYSTEMS

1. Please check if your child has had a problem with any of the following:

☐ Chest pain	☐ Heart condition	☐ Problem w/stomach intestines
☐ Cough	☐ Lethargy	
☐ Difficulty w/activity or exercise	☐ Muscle aches/joint issues	☐ Seizures or convulsions
	☐ Problem w/kidneys or bladder	☐ Shortness of breath
☐ Headaches		☐ Vomiting

2. Have there been any divorces, death, or other relevant family problems that might affect the child? ☐ No ☐ Yes – If yes, please describe:

3. Other – If you have any further notes/questions that you may not want to forget to ask the doctor, please write them below:

Patient or Representative Signature _____ Date _____ Time _____

If signed by someone other than the patient, please specify relationship to patient: _____

Interpreter Signature _____ Date _____ Time _____

Interpreter ID # _____