PEDIATRIC PULMONARY NEW PATIENT FORM- DR. WAN C. TSAI

Visit date: _____

Child's name: Last _____, First _____ Middle initial _____

DOB: _____ Age (in years and nearest months):_____

Primary Care Doctor: _____ Referring doctor: _____

Please indicate what problems your child has been referred for evaluation of:

PAST MEDICAL HISTORY

Birth history: What # baby for mother ____.

Was baby born prematurely? ___Yes ___No; if yes, gestational age ____weeks.

Birth weight _____ pounds _____ ounces;

Age of mother at time of baby's birth ___-year-old;

Complications during pregnancy _____

Circle whether vaginal / C-section delivery; Complications during delivery _____

Parental screen: Parents screened for any conditions (cystic fibrosis) prior to baby's birth? ___Yes ___No; _____

Newborn screen: Baby positive for any of the conditions screened at birth? ___Yes ___No;

Neonatal history: Baby stayed more than 2 days in nursery? ___Yes ___No;

Complications during stay? Please list: _____

If premature, how long was baby in NICU? _____

Was baby on breathing machine/ventilator? ___Yes ___No; If yes, how long? _____

Did baby transitioned to other breathing support like CPAP etc? ___Yes ___No; Please list _____. If yes, how long? _____

Was baby on oxygen? ___Yes ___No; If yes, how long? _____

Complications during NICU stay? Please list: _____

Feeding history:

Was baby breast fed ? ___Yes ___No If yes, how long? _____

Was baby bottle fed? ___Yes ___No If yes, list type of formula? _____

Did baby have vomiting and diarrhea tolerating formula? ___Yes ___No. If yes, how did symptoms resolved? _____

_____.

Did the baby spit up excessively ___Yes ___No; very colicky ___Yes ___No;

Any difficulties with feeding? ___Yes ___No; If yes, please list _____

Current problems with eating, diet? ___Yes ___No; If yes, please list _____

Developmental milestones

Any known delayed developmental milestones? _____

RESPIRATORY HISTORY (Please list all respiratory events in chronological order)

Date (at least season/year)	Age	what symptoms did child have	Diagnoses	Intervention/what was done for child

REVIEW OF SYSTEMS Has your child had any of the following problems?

Cough (at baseline, when "well")

Cough productive of sputum ___Yes ___No
During daytime ___Yes ___No
During nighttime ___Yes ___No
Awakens child up at night ___Yes ___No
Relieved with bronchodilators? ___Yes ___No
Relieved with steroids? ___Yes ___No
Cough occurs only with illness ___Yes ___No
Cough even when well ___Yes ___No if yes, how many times a week _____or a month _____

Wheezing (at baseline, when "well")

During daytime ___Yes ___No
Nighttime ___Yes ___No
Awakens child up at night ___Yes ___No
Relieved with bronchodilators? ___Yes ___No
Relieved with steroids? ___Yes ___No
Wheeze occurs only with illness ___Yes ___No
Wheeze even when well ___Yes ___No if yes, how many times a week _____or a month _____

Illness

Exacerbations are characterized by _____triggered by_____

How many oral steroid courses has child received over lifetime _____ or over the last year _____

Rescue bronchodilators are used ___Yes ___No

Other respiratory symptoms

Chest pain ___Yes ___No
Exercise intolerance ___Yes ___No; if yes, what symptoms with exercise _____
Shortness of breath ___Yes ___No
Cyanosis/turning blue ___Yes ___No
Breath holding spells ___Yes ___No; if yes, central or obstructive apneas? _____
Snoring ___Yes ___No; if yes, does child stop breathing with snoring? _____
Snorting/stertor ___Yes ___No
Stridor ___Yes ___No
Restless sleep ___Yes ___No

Respiratory infections: If yes to any of the below, please list how frequently (# in lifetime, # per year)

Ear infections ___Yes ___No _____
Colds/upper respiratory infections ___Yes ___No _____
Sinusitis ___Yes ___No _____
Bronchitis ___Yes ___No _____
Pneumonias ___Yes ___No _____

Allergic symptoms:

Did baby have infantile eczema? ___Yes ___No; If yes, at what age did eczema begin? _____ months old.
Rashes ___Yes ___No; If yes, ____all year round? _____seasonal?
Sniffles ___Yes ___No; If yes, ____all year round? _____seasonal?
Sneezing ___Yes ___No; If yes, ____all year round? _____seasonal?
Clear runny nose ___Yes ___No; If yes, ____all year round? _____seasonal?
Stuffy nose ___Yes ___No; If yes, ____all year round? _____seasonal?
Itchy, rubbing or picking nose ___Yes ___No; If yes, ____all year round? _____seasonal?

Other nasal symptoms _____

Itchy eyes ___Yes ___No; If yes, ____all year round? _____seasonal?
Water eyes ___Yes ___No; If yes, ____all year round? _____seasonal?
Headaches ___Yes ___No; If yes, ____all year round? _____seasonal?
Facial tenderness ___Yes ___No; If yes, ____all year round? _____seasonal?

Seasonality ___Yes ___No; If yes, please list _____

Has child seen an allergist? ___Yes ___No; If yes, Allergist: _____

Has child had allergy testing? ___Yes ___No; If yes, please circle: intradermal, skin prick, RAST blood test

Age at time of testing _____

Please list all allergen(s) to which child is reactive?

_____

Heartburn ___Yes ___No
Abdominal pain ___Yes ___No
Foreign body aspiration ___Yes ___No

PAST SURGICAL HISTORY

Has your child had an operation? ___Yes ___No If yes, please list in chronological order.

Date	Age	What procedure was done for child	What condition did child have

FAMILY HISTORY

Is there a history of the following problems in your family (brother/sister, parent, aunt/uncle, grandparent)? If yes, please write relationship.

Asthma ___Yes ___No _____
Hay fever ___Yes ___No _____
Severe allergies ___Yes ___No _____
Chronic lung disease ___Yes ___No _____
Cystic fibrosis ___Yes ___No _____
Failure to Thrive ___Yes ___No _____
Lactose Intolerance ___Yes ___No _____
Celiac disease ___Yes ___No _____
Inflammatory bowel disease ___Yes ___No _____
Immunodeficiencies ___Yes ___No _____
Hearing loss ___Yes ___No _____

Others _____

SOCIAL HISTORY

Who lives in household? _____

Number of brothers (and ages)_____ Sisters (and ages) _____

Parents: _____Married _____Separated _____Never Married

Mother's occupation _____ Father's occupation _____
Do parents bring home unusual dusts and fumes? ___Yes ___No
Known TB exposure? ___Yes ___No Recent travel abroad? ___Yes ___No
How old is your home? _____ Type of heating in the home _____.
Pets _____ indoors _____ outdoors _____.

Did mother smoke while pregnant? ___Yes ___No If yes, how many cigarettes per day? _____
Any smokers in the house now? ___Yes ___No
Outside the house ___Yes ___No
In the car ___Yes ___No
Is there significant secondary smoke exposure in the immediate home? ___Yes ___No
Is child cared for during day in an environment where adults smoke? ___Yes ___No
Can you attribute any increase in child's symptoms with smoke exposure? ___Yes ___No

ALLERGIES: Any adverse reaction to foods or medications _____

IMMUNIZATIONS: up to date? ___Yes ___No; including:
Influenza vaccination ___Yes ___No, if yes, when _____
Pneumococcal vaccine ___Yes ___No, if yes, when _____
Other lung-specific vaccines _____
Any reactions to immunizations? ___Yes ___No; If yes, please list:_____

CURRENT MEDICATIONS

Medication name	Dose	Route (mouth, inhaled, IV, injection)	Times given daily

MEDICAL EQUIPMENT
Durable medical equipment company: _____
Please list all medical equipment () that your child uses:

Brands/type	How is it given?	How many hours a day?
Nebulizer		
Oxygen		
Apnea monitor		
Others		

Mother's name: Last _____, First _____

Father's name: Last _____, First _____

Child's Address: _____

_____

Home phone: _____ other phone contact: _____

Would you like to be contacted by email? Email address: _____