Patient Name ________ Date of Birth ________ Today's Date ________

Houston Pediatric Pulmonary and Sleep Associates
New Patient Questionnaire - Pulmonary

Birth History

What hospital/birth center? ____________

C-section or vaginal delivery? ◯ c-section ◯ vaginal

What was the birth weight? ____________

What was the baby's gestational age at birth? ____________

How long was the baby in the hospital? ____________

Please list any problems/complications:

Past Medical History

Please list the patient's current medical problems: ☐ None

Please list all surgeries in the patient's lifetime: ☐ None

Surgery:	Date:	Surgeon:

Please list the patient's current medications (if additional room is needed, please provide attached list): ☐ None

Name: ☐ See attached.	Frequency/Dose/Strength:

Please list any allergies (medication, food, other): ☐ None

Please list any other medical specialists the patient has seen (ENT, allergist, cardiologist, etc.)

Please list how many times the patient has had/done the following (in the **past 1 year** of life or in the patient's **entire life**):

	Past Year:	Life:
Had an urgent visit to the doctor		
Went to the emergency room		
Admitted to the hospital		
Admitted to the ICU		
Intubated		
Taken a course of oral (by mouth) steroids		
Taken a course of antibiotics		

How many days of school did the patient miss in the last year for illness?

____

What is the name of your current home health care company?

____

Please list any special home medical equipment (oxygen, feeding pump, apnea monitor, etc.)

Family History

Please list the patient's siblings: ☐ None

Name:	Birth Date:	Gender:
		◯ M ◯ F
		◯ M ◯ F
		◯ M ◯ F
		◯ M ◯ F
		◯ M ◯ F

Are there any medical problems in the family? Be sure to include any breathing or allergy problems.

Family Member	Disease/Problem ☐ None

Patient Name ☐ Date of Birth ☐ Today's Date ☐

Social History

Does patient attend any type of daycare? ☐ Yes ☐ No

Does anyone the patient knows smoke? ☐ Yes ☐ No

Please list any pets in the home, or other animals to which the patient is exposed. ☐ None

Who lives with the patient at home?

Are there any problems with the conditions of the patient's home (water damage, mold, insects, pests, peeling paint)? Explain: ☐ Yes ☐ No

How often are the air conditioning filters changed?

What grade is the patient currently in?

What sports does the patient play currently?

What other hobbies or activities is the patient involved in currently?

Does the patient live close to any industrial refineries, chemical factories, or other industrial plants? ☐ Yes ☐ No

Does the patient's bedroom have:

Carpet	☐ Yes	☐ No
Curtains	☐ Yes	☐ No
Ceiling fan	☐ Yes	☐ No
Stuffed animals	☐ Yes	☐ No

Review of Systems

Constitutional

Fever or chills (recent, or recurrent)	☐ Yes	☐ No
Night sweats	☐ Yes	☐ No
Weight ◯ loss or ◯ gain	☐ Yes	☐ No
Decreased energy	☐ Yes	☐ No
Appetite changes	☐ Yes	☐ No
Difficulty gaining weight	☐ Yes	☐ No

Eye

Itchy eyes	☐ Yes	☐ No
Watery eyes	☐ Yes	☐ No
Red eyes	☐ Yes	☐ No
Vision Problems	☐ Yes	☐ No

Ear, Nose, Mouth, & Throat

Runny Nose	☐ Yes	☐ No
Nasal congestion	☐ Yes	☐ No
Frequent sinus infections	☐ Yes	☐ No
Frequent sniffing or sneezing	☐ Yes	☐ No
Frequent throat clearing	☐ Yes	☐ No

Neurological

Frequent headaches	☐ Yes	☐ No
Convulsions or seizures	☐ Yes	☐ No
Developmental delays	☐ Yes	☐ No
Is or was your child enrolled in ECI	☐ Yes	☐ No
Does your child require special classes in school	☐ Yes	☐ No
Does your child require therapy	☐ Yes	☐ No

If yes, please identify ◯ Speech ◯ Language ◯ Physical ◯ Occupational

Cardiovascular

Heart murmur or heart problem	☐ Yes	☐ No
Chest pain	☐ Yes	☐ No
Exercise limitation	☐ Yes	☐ No
Fainting Spells	☐ Yes	☐ No

Sleep

Snores more than 3 nights per week	☐ Yes	☐ No
Episodes where patient stops breathing while sleeping	☐ Yes	☐ No
Chokes/gags/gasps/snorts while sleeping	☐ Yes	☐ No
Too sleepy during the day	☐ Yes	☐ No
Falls asleep at inappropriate times	☐ Yes	☐ No
Bed wetting	☐ Yes	☐ No

Gastrointestinal

Vomiting or excessive spit up	☐ Yes	☐ No
Constipation	☐ Yes	☐ No
Heart burn	☐ Yes	☐ No
Frequent abdominal pain	☐ Yes	☐ No
Frequent burping	☐ Yes	☐ No
Frequent hiccups	☐ Yes	☐ No
History of iron or other nutritional deficiency	☐ Yes	☐ No

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Allergic/Immunologic

Eczema (dry, rough, or itchy skin)	☐ Yes	☐ No
Hives (urticaria)	☐ Yes	☐ No
Allergies (allergic rhinitis, hay fever, etc.)	☐ Yes	☐ No

Endocrine

Too hot or too cold	☐ Yes	☐ No
Blood sugar problems (including diabetes)	☐ Yes	☐ No
Easy bruising	☐ Yes	☐ No
Take birth control pills	☐ Yes	☐ No

Other

Please note any other important symptoms not listed above:

____

____

____

Psychiatric

Symptoms of anxiety (excessive worries)	☐ Yes	☐ No
Symptoms of depression (hopeless, helpless, excessive sadness, crying)	☐ Yes	☐ No
Behavioral problems (fighting at school)	☐ Yes	☐ No
Other psychiatric conditions	☐ Yes	☐ No

Musculoskeletal

Scoliosis (curved spine)	☐ Yes	☐ No
Back Pain	☐ Yes	☐ No
Joint pain or swelling	☐ Yes	☐ No
Muscle weakness	☐ Yes	☐ No