CHILDREN'S LUNG SPECIALISTS QUESTIONAIRE
NEW PATIENTS

Please complete this *entire* questionnaire as best as you can. This will help us to treat your child in the best way possible.

Patient Name: ______________________

Birthdate: ______________________

Today's date: ______________________

Patient's primary physician: ______________________

Any subspecialist physicians: ______________________

____

____

____

____

____

What is the reason patient was referred to us?

____

____

IMMUNIZATIONS

Are the patient's immunization up to date: ☐YES ☐NO

If not, which immunizations have they not received and why?

____

Did the patient receive the flu shot in the past 12 months? ☐YES ☐NO

Any past allergic reaction to the flu shot? ☐YES ☐NO

FOOD ALLERGIES

Does the patient have any food allergies? ☐YES ☐NO

If yes, to what and what is their reaction? *(example: peanuts – hives)*

____

SEASONAL/PET ALLERGIES

Does the patient have any seasonal or pet allergies? ☐YES ☐NO

If yes, to what and what is their reaction? *(example: cats – runny nose & itchy eyes)*

____

Did they ever have allergy testing (skin or blood test)? ☐YES ☐NO

DIET

Is patient on any special diet? ☐YES ☐NO *If yes*, what?____________________

If patient is an infant, on average, how many ounces per feed (if breastfeeding, how long) and how many feeds per 24 hours? *(example: 3 oz, 8 feeds per 24hrs)*____________________

If patient is on G-tube feed, what is it, how much do you give, when do you give it, and over how long? *(example: Peptamen Jr 1 can bolus 3 times per day + 3 cans over 8 hours at night)*

____

EMERGENCY DEPARTMENT VISITS

Has the patient ever had to go the Emergency Room? ☐YES ☐NO

If yes, when and for what reason:

DATE	REASON FOR EMERGENCY ROOM VISIT

SURGERIES

Has the patient ever had any surgeries? ☐YES ☐NO

If yes, when and for what reason:

DATE	REASON FOR SURGERY

DOES THE PATIENT HAVE ANY OF THE FOLLOWING SYMPTOMS?

1.) Fever in the past 7 days?	☐NO	☐YES
2.) Weight loss or poor weight gain?	☐NO	☐YES
3.) Poor energy?	☐NO	☐YES
4.) Frequent itchy eyes?	☐NO	☐YES
5.) Frequent runny nose or nasal congestion?	☐NO	☐YES
6.) Episodes of turning blue in the face (lips, tongue)?	☐NO	☐YES
7.) Frequent chest pain?	☐NO	☐YES
8.) Easy fatigue with exercise?	☐NO	☐YES
9.) Shortness of breath?	☐NO	☐YES
10.) Working hard to breathe (chest retractions, i.e. deep sucking in of the skin in or around the bones of the chest)?	☐NO	☐YES
11.) Frequent noisy breathing?	☐NO	☐YES
12.) Wheezing or whistling sound coming from their chest?	☐NO	☐YES
13.) Frequent coughing during the day?	☐NO	☐YES
14.) Frequent coughing while asleep?	☐NO	☐YES
15.) Frequent chest pain, heartburn, sour taste in mouth, spit-ups, or pain/fussiness within 30 to 60 minutes after eating?	☐NO	☐YES
16.) Diarrhea?	☐NO	☐YES
17.) Stools that appear greasy/oily or typically float rather than sink?	☐NO	☐YES
18.) Frequent coughing or choking while eating/drinking?	☐NO	☐YES
19.) Snoring?	☐NO	☐YES
20.) Gasping for air while asleep?	☐NO	☐YES
21.) Progressive weakness of muscles?	☐NO	☐YES
22.) Frequent headaches?	☐NO	☐YES
23.) Blood colored urine?	☐NO	☐YES
24.) Swelling of face, arms, or legs?	☐NO	☐YES
25.) Easy bruising of skin?	☐NO	☐YES
26.) Bleeds with brushing teeth or prolonged bleeding with cuts?	☐NO	☐YES
27.) Joint swelling or redness or pain?	☐NO	☐YES
28.) Rashes?	☐NO	☐YES
29.) Depression or suicidal thoughts?	☐NO	☐YES