



Medical Record #: _____

Date of Visit: _____

PEDIATRIC PULMONOLOGY NEW PATIENT QUESTIONNAIRE

Name: _____ Birth Date: _____ Age: _____

Referring Doctor: _____ Patient's other doctors: _____

Reason for visit (describe briefly) _____

CHEST SYMPTOMS:

Age of onset of earliest symptoms: _____

Wheezing N / Y _____
 Tightness in chest N / Y _____

Cough N / Y _____
 Dry N / Y _____
 Productive (of mucus) N / Y _____
 Daily N / Y _____
 Periodic/Nocturnal N / Y _____
 Worse during the day N / Y _____

Chest Pain N / Y _____

Shortness of breath N / Y _____
 With exercise N / Y _____
 With changes in weather N / Y _____
 Anytime N / Y _____

Vomiting with coughing N / Y _____
 Spitting up or reflux N / Y _____

Fever N / Y _____
 Night Sweats N / Y _____
 Chills N / Y _____

Frequency of chest symptoms: Daily: _____ Weekly: _____ Monthly: _____ Nocturnal: _____

Time of year when symptoms are worse: _____

What are symptoms aggravated by? _____

Frequency of colds or upper respiratory tract infections
 Per year: 1-3: _____ 3-6: _____ More than 6: _____

Would you classify your child's infections as: Throat: _____ Ear: _____ Sinuses: _____ Bronchitis: _____

Had your child ever had pneumonia? N / Y, Date: _____

Tonsillectomy and/or adenoidectomy? N / Y, Date: _____

NASAL SYMPTOMS:

Age of onset of earliest symptoms: _____

Frequency of symptoms: Constant _____ Seasonal _____

Times of year symptoms are worse _____

Nasal symptoms lead to chest symptoms: N / Y Describe nasal secretions: _____

What are symptoms aggravated by? _____

Symptoms worse in certain places? N / Y, where? _____



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Has your child ever received treatment for:

Remarkable nose bleeds	N / Y	Sinus X-rays	N / Y
Nasal polyp	N / Y	Sinus surgery	N / Y
Nasal septal deformity	N / Y	Broken nose	N / Y
Sinusitis (sinus infection)	N / Y		

EYE SYMPTOMS:

Does your child have eye symptoms? N / Y, If yes, please explain _____

What aggravates symptoms? _____

EAR SYMPTOMS:

Does your child have ear problems? N / Y, If yes, please explain _____

Has your child had ear tubes placed? N / Y

When? _____

HEADACHES:

Does your child have headaches? N / Y

Frequency: Rare _____ Daily _____ Weekly _____ Monthly _____

Severity: Mild _____ Moderate _____ Sever _____ Throbbing _____

SKIN RASHES:

N / Y, If yes, please explain _____

Has your child ever had hives? N / Y _____

List things that cause child's hives _____

FOOD PROBLEMS:

Is your child allergic to any foods? N / Y If yes, please explain _____

Is your child intolerant of any foods? N / Y If yes, please explain _____

Please list:

FOOD	DATE	REACTION

INSECT SENSITIVITY:

Has your child ever had severe reactions from insect bites or stings? N / Y

Description of symptoms: Swelling: N / Y Breathing difficulties: N / Y

Hives: N / Y Fainting: N / Y

Other symptoms: _____

Any other allergies? Do not include medications _____

ENVIRONMENTAL SURVEY:

Time lived in present home? _____ Approximately how old is the home? _____

House / Apartment _____ City / Rural _____

Heat? N / Y Central _____ Space heater(s) _____ Do you use an electric air filter? N / Y

Does anybody that live in your child's household smoke? N / Y, who? _____

Is your child in school or daycare? N / Y, how many days a week? _____

BEDROOM: Pillows: Feather? _____ Foam? _____ Fiber filled? _____ Is pillow encased? N / Y

Bed coverings: What are they made of? _____ Any feather filled items? N / Y

Mattress: How old? _____ Covered by: Cotton _____ Vinyl _____ Other _____



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Stuffed animals? N / Y Carpeting? N / Y Ceiling Fans? N / Y Pets _____
 Window coverings: Curtains _____ Blinds _____ (horizontal or vertical) Shades _____
 Do you use a vaporizer or humidifier in your child's room? N / Y When? _____
 Has your child ever had allergy tests and/or treatment? N / Y, if so, by whom _____

Location of previous residences:
 City _____ Symptoms better, worse, or the same? _____

BIRTH HISTORY:

Full Term? N / Y _____ Birth weight _____ any complications? _____

DIET: _____ **APPETITE:** Good / Fair / Poor. Explain: _____

STOOLS: Formed _____ Loose _____ Oily _____ Foul Smelling N / Y # of Stools/day _____

Any problems with constipation or diarrhea? _____

PAST MEDICAL HISTORY:

Ever been in the intensive care unit? _____ Ever been on a respirator? _____

List all hospitalizations / operations / emergency room visits	Date	Diagnosis
_____	_____	_____
_____	_____	_____
_____	_____	_____

Any family medical history of asthma, lung problems, allergies/hay fever, sinus problems, Cystic fibrosis, Tuberculosis or recurrent infections? Explain

Does your child have any medication allergies? N / Y. Explain reaction, drug name or approximate date

Are your child's immunizations up to date? N / Y _____

FLU vaccine: N / Y, date of last _____ Pneumovax / Prevnar vaccine: N / Y, date of last _____

Please list all meds currently using (prescribed and over the counter):

Medication	Dose	How often used	Helpful (N / Y)
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

In the space below, describe any other symptoms / conditions that were not covered in this questionnaire.

