NAME: _____

DOB: _____

RETURNING PATIENT INFORMATION

We appreciate the opportunity to partner with you in the health of your child. We ask you to complete this information carefully and legibly. Thank you!

List all current medications with dose and frequency:

_____ _____

_____ _____

_____ _____

Do you have any Asthma Action Plan drugs on hand at home? (please circle all that apply.)

Albuterol Xopenex Orapred or Prednisolone Prednisone Medrol

In the last week or two, have there been changes in health including flu or colds?
____NO ____YES (please describe)

_____

_____

SINCE YOUR LAST VISIT

Since last visit, have there been any respiratory complaints which caused:

Hospitalizations? ____NO ____YES When/How Many? _____

Emergency Room Visits? ____NO ____YES When/How Many? _____

Acute Doctor Visits? ____NO ____YES When/How Many? _____

Courses of Oral Steroids? ____NO ____YES When/How Many? _____

Since last visit, describe asthma control during a typical week when child is not ill:

Cough? ____ NONE ____OCCASIONAL ___FREQUENT ____CONSTANT

Activity/Exercise Interference? ____ NONE ____OCCASIONAL ___FREQUENT ____CONSTANT

Sleep Disturbance? ____ NONE ____OCCASIONAL ___FREQUENT ____CONSTANT

Need for Albuterol/Xopenex? ____ NONE ____OCCASIONAL ___FREQUENT ____CONSTANT

Since last visit, please describe the following:

Allergic Rhinitis/Hay Fever? _____DON'T HAVE _____ CONTROLLED _____ NOT CONTROLLED

Atopic Dermatitis/Eczema? _____DON'T HAVE _____ CONTROLLED _____ NOT CONTROLLED

Gastroesopheal Reflux? _____DON'T HAVE _____ CONTROLLED _____ NOT CONTROLLED

SINCE YOUR LAST VISIT

Please list any recent symptoms or complaints in the following areas, since last visit:

Health Overall – for example change in appetite, chills, fatigue, weight gain or loss, etc.

____NO _____YES (describe) _____

Eyes – for example visual changes, blurred vision, eye drainage, sensitivity to light, etc.

____NO _____YES (describe) _____

Ears, Nose, and Throat – for example sore throat, hearing changes, sinus drainage, etc.

____NO _____YES (describe) _____

Heart – for example heart murmur, heart palpitations, chest tightness, dizziness, etc.

____NO _____YES (describe) _____

Stomach and Intestines – for example abdominal pain, change in stools, heartburn, indigestion

____NO _____YES (describe) _____

Bladder or Kidney – for example urinary problems, blood in urine, frequent bladder infections, etc.

____NO _____YES (describe) _____

Muscle or Skeleton – for example arthritis, back pain, joint stiffness or pain, weakness, etc.

____NO _____YES (describe) _____

Skin – for example change in moles, acne, rashes, sores, etc.

____NO _____YES (describe) _____

Neurological – for example fainting, headaches, memory problems, numbness or tingling, etc.

____NO _____YES (describe) _____

Psychological – for example anxiety, depression, mood swings, poor concentration, etc.

____NO _____YES (describe) _____

Diabetes/Thyroid – for example cold or heat intolerance, hair loss, excessive thirst, etc.

____NO _____YES (describe) _____

Bleeding/Anemia – for example blood clotting problems, easy bruising, excessive bleeding, etc.

____NO _____YES (describe) _____

Other?

_____

PATIENT MEDICAL HISTORY – SINCE BIRTH

Please list any symptoms, complaints, or diagnosis in the following areas since birth:

Health Overall? ____NO ____YES (describe) _____

Eyes? ____NO ____YES (describe) _____

Ears, Nose, and Throat? ____NO ____YES (describe) _____

Heart? ____NO ____YES (describe) _____

Stomach and Intestines? ____NO ____YES (describe) _____

Bladder or Kidney? ____NO ____YES (describe) _____

Muscle or Skeleton? ____NO ____YES (describe) _____

Skin? ____NO ____YES (describe) _____

Neurological? ____NO ____YES (describe) _____

Psychological? ____NO ____YES (describe) _____

Diabetes/Thyroid? ____NO ____YES (describe) _____

Bleeding/Anemia? ____NO ____YES (describe) _____

Other Comments? _____

_____

PAST SURGERIES? _____None _____Yes, Please describe: _____

_____

_____

PATIENT SOCIAL ENVIRONMENT

Please circle the answer which best represents the patient's current living arrangements?

With: PARENTS MOTHER FATHER SPLIT TIME GRANDPARENT(S)

Is your family involved with the Department of Human Services in any capacity? _____NO

If yes, please describe: _____

Where does patient spend time during the day?

DAYCARE: (Number of days during week?) _____

PRESCHOOL: (Number of days during week?) _____

SCHOOL: (Number of days during week?) _____

BROTHERS? ____None Yes-Ages: _____

SISTERS? ____None Yes-Ages: _____

PATIENT ENVIRONMENTAL HISTORY – Information on home and neighborhood

CITY: _____

HOME?: SINGLE-FAMILY **What year was the house built?** _____

APARTMENT TRAILER DUPLEX

BASEMENT?: NONE UNFINISHED FINISHED **Is the basement** ____DAMP or ____DRY?

HOME CLIMATE CONTROL?: CENTRAL AIR WINDOW UNIT

CENTRAL FORCED HEAT RADIATOR HEAT BASEBOARD HEAT FIREPLACE

WOOD BURNING STOVE AIR PURIFIERS OTHER _____

PATIENT'S BEDROOM: NUMBER OF BEDS IN ROOM _____

BEDS HAVE DUST MITE COVERS ____NO ____YES

NUMBER OF PEOPLE SLEEPING IN ROOM _____

FLOOR COVERINGS? WOOD CARPET AREA RUG

PETS?: NONE CAT(S) _____ DOG(S) _____ OTHER: _____

DO PETS HAVE ACCESS TO BEDROOM? _____

INDUSTRIAL OR AGRICULTURAL POLLUTION IN NEIGHBORHOOD?: _____NO

If yes, please describe? _____

SMOKER EXPOSURE: ____NO _____YES Who? _____

Does smoker limit direct contact by smoking outdoors only? _____

Does patient smoke? ____NO _____YES How often? _____

PRIMARY CARE PHYSICIAN?: _____

Location?: _____

PREFERRED PHARMACY?: _____

Location?: _____

FAMILY MEDICAL HISTORY - Please circle any that apply for patient's immediate family and/or grandparents

RESPIRATORY	Asthma	Pulmonary Embolism	Pulmonary Hypertension	Sleep Apnea	Tuberculosis	Sarcoidosis	Emphysema	COPD	Cystic Fibrosis
EYES/VISION	Retinitis Pigmentosa	Osler's Disease	Blindness	Glaucoma	Acoustic Neuroma	Color Blindmess			
EARS, NOSE, THROAT	Strabisms	Otosclerosis	Meniere's Disease	Allergic Rhinitis	Deafness	Cataracts	Macular Degeneration		
HEART	Arrhythmia	Coronary Disease	Cardiac Murmurs	Congestive Heart Failure	Congenital Heart Anomaly	Hypertension	Myocardial Infarction	Hyper Lipidemia	
STOMACH/ INTESTINES	GERD	Hernia	IBS	Barrett's Esophagus	Crohn's Disease	Esophageal Disorder	Hepatitis		
BLADDER/ KIDNEY	Chronic Kidney Disease	Polycystic Kidney Disease	Renal Failure						
MUSCLE/ SKELETON	Fibromyalgia	Myopathy	Scoliosis	Rheumatoid Arthritis	Gout	Osteopenia	Polymyositis	Osteoarthritis	
SKIN	Eczema	Psoriasis	Seborrheic Dermatitis		**IMMUNE**	Anaphylaxis	HIV/AIDS	Immuno-deficiency	
NEUROLOGIC	Cerebral Palsy	Epilepsy	Mental Retardation	Migraines	Multiple Sclerosis	Seizure Disorder	Stroke	Headaches	
PSYCHIATRIC	ADD	ADHD	Bipolar Disorder	Depression	Eating Disorder	Anxiety			
ENDOCRINE	Addison's Disease	Diabetes Type 1	Diabetes Type 2	Hyper-thyroidism	Hypo-thyroidism	Cushing's Disease			
BLOOD	Hemophilia	Pernicious Anemia	Sickle Cell Disease	DVT	Thrombo-cytopenia	Factor Vill Deficiency			
CANCER	Brain Tumor	Breast Cancer	Cervical Cancer	Leukemia	Colon Cancer	Lung Cancer	Lymphoma		

Other? _____

Is child adopted? _____NO _____YES