*St.Vincent Pediatric Pulmonology and Sleep Medicine*
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# Medical History for Pediatric Pulmonology (revised 08 04 2012)

**Patient's full name:**_____

**Date of birth:**_____

**Name of Person filling out this form:** _____

**Relation to patient:**_____

**Date form was filled:**_____

Please complete this history form as completely as possible so your visit to the doctor will be the most beneficial.

**Birth History**

Birth weight_____ C-section? No / Yes. How long did baby have to stay in hospital?
Born at due date? No / Yes. If not how many weeks early or late
☐ NICU stay? No / Yes. If so where?_____
Complications:_____
Ventilator or breathing tube? No/Yes Feeding difficulties? No/Yes Brain Injury? No/Yes
Other_____

**Past illnesses**

Any chronic diseases as infant(baby eczema, spit up, colic, breathing problems, RSV virus)?
Any other medical problems? No / Yes._____
☐ Ever seen by any other specialists? No / Yes. Who and where?_____
_____
_____
☐ Any hospitalizations ER or Urgent care visits for breathing issues? No / Yes.
What and which hospital?_____
_____
Ever had: pneumonias, asthma attacks, sinus infections
☐ Any Surgeries or Procedures done? No / Yes. _____
If so what and Where were they preformed?_____ _
☐Allergies to medicines? No/Yes. if so what medicine_____
what reaction was there?_____
Allergies to anything else? No/Yes. _____
what reaction was there?_____
☐ Any allergy testing done? No / Yes. Do you know results? No / Yes.
Where were they done?_____
☐ Any other breathing tests, Blood work, x-ray tests or swallow studies? No / Yes.
☐ Ever had a cystic fibrosis test? No / Yes. Where was it done?_____

Ever had a TB skin test? No / Yes. Do you know results? No / Yes. Where were they done?

Missing School due to illness? No / Yes. If so how much this year?_____

**Previous medications**

What breathing medications have been used? _____

Were the medicines affective?_____

Do you have a nebulizer machine for medicine delivery? Yes / No

Current medications *__Current Pharmacy and Number__: _____

| Medicine name | Concentration | Dose | Frequency | Reason |
|---|---|---|---|---|
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Please use additional sheets if needed

**Family history** (please indicate the problem and who in relation to the patient has it)

Breathing problems

Asthma, Cystic fibrosis

Chronic Bronchitis/ COPD/ Emphysema

Tuberculosis or positive TB skin test

Allergies

Sinus / ear problems

Sleep problems(sleep apnea or narcolepsy, use of cpap machine)

Eczema or other skin problems

Acid reflux (GERD), Hiatal hernia

Heart problems

Immune or autoimmune problems ( Lupus, rheumatoid arthritis)

Endocrine , diabetes or thyroid problems

Kidney/urinary tract

Liver

Neurologic (seizures, developmental, psychiatric)

Cancer

**Social history**

Who lives with the patient? _____ Any siblings, if so how old?_____

Who is the primary care taker?_____

Any daycare or school attendance currently? No / Yes. Recent patient or family travel? No / Yes.

Any close contacts ill currently? No/Yes. Any visitors from another country? No / Yes.

Patient Live In city or on farm?_____ Are there crops or woods nearby? No / Yes.

What kind of home is it?(House, Mobile home, apartment) how old is it?_____

Is there any mold damage or leaks? No / Yes. Is the basement wet or moldy? No / Yes.

Is there a fireplace, wood burning heating stove in the home? No/Yes.

if so how often do you use it._____

Is there carpet or stuffed animals in the patient's room? No / Yes.

List of Pets:_____ Inside home? No/Yes. Inside patient's room? No / Yes.

Other animals, Livestock, birds, rodents, bats, or roaches?

Does anyone in family smoke? No / Yes. Who and how much?_____

Do they smoke in the home or in the car? No / Yes.

Does the child play any sports or do other activities out of school?_____

**Review of current symptoms** (please check boxes if these problems or symptoms are present so the doctor can help evaluate the patient's overall health)

| **Physical-any pertain** | **Sleep** | **Hemo/Lymph** | **Genito-urinary** |
|---|---|---|---|
| ☐ **None apply** | ☐ **None apply** | ☐ **None apply** | ☐ **None apply** |
| ☐ recent/recurrent fevers | ☐ stop breathing in sleep | ☐ bruising | ☐ frequent urination |
| ☐ weight gain | ☐ restless sleep | ☐ bleeding | ☐ burning on urination |
| ☐ weight loss/poor wt. gain | ☐ bed wetting | ☐ swollen glands | ☐ painful urination |
| ☐ tiredness/fatigue | ☐ nightmares/terrors | **Endocrinology** | ☐ low back/ flank pain |
| ☐ night sweats | ☐ daytime sleepiness | ☐ **None apply** | ☐ dark/bloody urine |
| **Ear, Nose, and Throat** | ☐ attention/behavior issues | ☐ thyroid- high/ low | **Neurological** |
| ☐ **None apply** | ☐ daytime naps | ☐ growth failure | ☐ **None apply** |
| ☐ runny nose | ☐ falls asleep at school | ☐ steroid problems | ☐ head aches |
| ☐ bloody nose | **Gastrointestinal/Stomach** | ☐ metabolic disorder | ☐ seizures |
| ☐ sinus congestion | ☐ **None apply** | **Skin** | ☐ autism |
| ☐ sinus pain | ☐ nausea | ☐ **None apply** | **Neurological** |
| ☐ ear problems | ☐ regurgitation/ spitting up | ☐ rashes | ☐ **None apply** |
| ☐ eye problems | ☐ vomiting | ☐ eczema | ☐ seizures |
| ☐ throat pain | ☐ heartburn | ☐ psoriasis | ☐ autism |
| ☐ tonsillitis | ☐ abdominal pain | ☐ hemangioma | |
| **Respiratory/Lung** | ☐ diarrhea | **Musculo-skeletal** | |
| ☐ **None apply** | ☐ greasy stools | ☐ **None apply** | |
| ☐ cough | ☐ bloody stools | ☐ joint pain | |
| ☐ coughing up blood | ☐ constipation | ☐ back pain | |
| ☐ coughing up mucus | ☐ other bowel problems | ☐ scoliosis | |
| ☐ wheezing | ☐ gags on food | ☐ cerebral palsy | |
| ☐ noisy breathing | ☐ chokes on liquids | ☐ muscular dystrophy | |
| ☐ chest pain | ☐ chokes on solids | **Genito-urinary** | |
| ☐ passing out | ☐ texture problems | ☐ **None apply** | |
| ☐ shortness of breath | ☐ refuses food | ☐ frequent urination | |
| **Cardiovascular/Heart** | **Allergy/Immunology** | ☐ burning on urination | |
| ☐ **None apply** | ☐ **None apply** | ☐ painful urination | |
| ☐ murmurs | ☐ allergies/reactions | ☐ low back/ flank pain | |
| ☐ skipping beats or fast beats | ☐ hay fever | ☐ dark/bloody urine | |
| ☐ fast rate with medications | ☐ immune problems | | |

In your own words, briefly, what brings you to see the lung doctors at this occasion?

_____

_____

_____

_____

Medical provider has reviewed and annotated this form. See full record for additions.

Signature of Doctor:

Date and time of doctor evaluation: