Rady Children's Hospital San Diego

Rady Children's Hospital - San Diego
3020 Children's Way
San Diego, CA. 92123

DTF806

PATIENT INFORMATION

Name: _____
MR#: _____ Finance: _____
DOB: _____
MD: _____

Pediatric Pulmonary New Patient Questionnaire

Patient Name:	Today's Date:	Date Of Birth:	M F
Parents: Father's Name:	Mothers Name:		
Legal Guardian Name:			

PREGNANCY/BIRTH (PLEASE DESCRIBE ANY YES ANSWERS)

What was the baby's weight at birth?

How many weeks pregnant was mother when the baby was born?

Was the baby delivered by c-section or vaginally? ☐ c-section ☐ vaginally

Were there any problems during labor or delivery? ☐ **N O** ☐ **YES**

Any problems during the nursery stay? ☐ **NO** ☐ **YES**

Did the baby stay in the special care nursery? ☐ **NO** ☐ **YES**

Were there any problems during the mother's pregnancy? ☐ **NO** ☐ **YES**

Where there any difficulties feeding? ☐ **NO** ☐ **YES**

ILLNESSES AND OTHER PROBLEMS:

HOSPITAL STAYS AND SERIOUS ILLNESS

Date:	Hospital:	Problem:
Date:	Hospital:	Problem:
Date:	Hospital:	Problem:

OPERATIONS AND/OR ACCIDENTS

Date:	Describe:
Date:	Describe:
Date:	Describe:

CHRONIC MEDICAL CONDITIONS

Any Chronic Medical Conditions ☐ **No** ☐ **Asthma** ☐ **Other:**

MEDICATIONS

Please list all prescription medications that your child is currently taking, include strength/dosage as well as frequency.

Please include over-the-counter medicines also. ☐ NO PRESCRIPTION MEDICINES

Name:	**Dose :**	**Frequency:**
#1		
#2		
#3		
#4		
#5		
#6		

Pediatric Pulmonary New Patient Questionnaire Continued

Allergies Please list Any Allergies to Medications or Foods ☐ None Known

Are Immunizations Current? ☐ Yes ☐ No If No, please describe:

FAMILY HISTORY

Please identify any of the following that a family member or relative may have

	Asthma or wheezing		**Allergies**		**Diabetes**
	Sudden unexplained death		**Cystic Fibrosis**		**Anemia/Blood Diseases**
	SIDS or infant death		**Congenital Lung Defects**		**Immune Deficiency**
	Recurrent pneumonias		**High Blood Pressure**		**Childhood Cancers**

Immediate Family Members

Member	**DOB**	**Healthy Y/N**	**Problems**
Mother		☐ Yes ☐ No	
Father		☐ Yes ☐ No	
Brother		☐ Yes ☐ No	
Brother		☐ Yes ☐ No	
Brother		☐ Yes ☐ No	
Sister		☐ Yes ☐ No	
Sister		☐ Yes ☐ No	
Sister		☐ Yes ☐ No	

Are Father and Mother and all brothers and sisters alive? ☐ Yes ☐ No

SOCIAL HISTORY

Patient Lives With? Check All That Apply:

☐ **Mother** ☐ **Father** ☐ **Brother(s)** ☐ **Sister(s)** ☐ **Grandparents** ☐ **Others**

Grade In School:

Any smokers in the home? ☐ None ☐ Mother ☐ Father ☐ Others

Any Pets in the home? ☐ None ☐ Dogs ☐ Cats ☐ Other

Relationship of Individual Completing This Form To Patient ☐ Patient ☐ Parent ☐ Guardian

Signature:

Reviewed By: Date:

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PEDIATRIC PULMONARY QUESTIONNAIRE

Name: _____ Age: _____ Today's Date: _____

Do you have any particular concerns today? __Yes __No

If yes, please explain: _____

_____

_____

Please make sure to fill out completely, if non-applicable mark "None" in each corresponding box and sign. Thank you.

Pediatric Review of Systems (check all that apply)		
General: □ None □ poor weight gain □ recent weight loss □ frequent fevers □ fatigue (tiredness) □ paleness	**Cardiovascular: □ None** □ heart murmur □ chest pain □ blue spells □ high blood pressure □ swelling in hands/feet □ palpitations (fluttering in heart , fast beats) □ syncope (passing out) □ high cholesterol	**Skin: □ None** □ eczema □ rashes □ itching □ dryness □ hemangiomas/birthmarks
Ears/Nose/Throat: □ None □ frequent ear infections □ ear drainage □ weak cry □ hearing loss □ sinus trouble/frequent infections □ nosebleeds □ seasonal or chronic runny nose □ nasal congestion □ sneezing	**Gastrointestinal: □ None** □ coughing/choking/gagging w/eating □ frequent vomiting □ constipation □ frequent diarrhea/loose stools □ frequent heartburn/stomach aches □ blood in stool	**Neurologic: □ None** □ speech problems □ headaches □ seizures □ weakness □ school problems
Eyes: □ None □ glasses/contact lenses/vision changes □ eye pain □ eye redness □ watery eyes	**Endocrine: □ None** □ excessive urination □ diabetes □ excessive thirst/ hunger **Genitourinary: □ None** □ pain or burning with urination	**Heme/Lymphatic: □ None** □ anemia □ enlarged lymph nodes □ easy bruising/bleeding
Respiratory: □ None □ wheezing □ coughing □ chest pain □ noisy breathing	**Musculoskeletal: □ None** □ muscle pain □ limp □ recent trauma/fractures □ joint pain or stiffness □ joint/muscle swelling	**Psychiatric: □ None** □ problems at school □ depression □ sleep disturbance

Relationship of Individual Completing This Form To Patient ☐ Patient ☐ Parent ☐ Guardian

X **Signature:**

Reviewed By: Date: