

## New Patient Intake Form

### The Pediatric Lung Center

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Patient name: \_\_\_\_\_ Age: \_\_\_\_\_ Today's date: \_\_\_\_\_

Chief symptom: \_\_\_\_\_ Date symptoms started: \_\_\_\_\_

#### SYMPTOMS:

- |                                      |   |   |   |
|--------------------------------------|---|---|---|
| <b>Eyes</b>                          | <input type="checkbox"/> Itching  | <input type="checkbox"/> Redness  | <input type="checkbox"/> Tearing/Watering   |
| <b>Ears</b>                          | <input type="checkbox"/> Itching  | <input type="checkbox"/> Popping  | <input type="checkbox"/> Fluid <input type="checkbox"/> Clicking  |
| <b>Throat</b>                        | <input type="checkbox"/> Itching  | <input type="checkbox"/> Throat clearing  |   |
| <b>Nose</b>                          | <input type="checkbox"/> Congestion<br><input type="checkbox"/> Nose rubbing  | <input type="checkbox"/> Runny nose<br><input type="checkbox"/> Post nasal drip   | <input type="checkbox"/> Sneezing <input type="checkbox"/> Itching  |
| <b>Skin</b>                          | <input type="checkbox"/> Eczema<br><input type="checkbox"/> Contact dermatitis  | <input type="checkbox"/> Atopic dermatitis<br><input type="checkbox"/> Poison Ivy   | <input type="checkbox"/> Hives: <input type="checkbox"/> In the past <input type="checkbox"/> Now   |
| <b>Gastrointestinal</b>              | <input type="checkbox"/> Heartburn  | <input type="checkbox"/> Burping  | <input type="checkbox"/> Nausea/vomiting <input type="checkbox"/> Diarrhea  |
| <b>Cough</b>                         | <input type="checkbox"/> Waking up in the AM<br><input type="checkbox"/> Dry<br><input type="checkbox"/> Every day              | <input type="checkbox"/> Throughout the day<br><input type="checkbox"/> Produces sputum<br><input type="checkbox"/> 3x a week | <input type="checkbox"/> Awakened at night <input type="checkbox"/> With exercise<br><input type="checkbox"/> Once a week <input type="checkbox"/> Once a month |
| <b>Shortness of breath</b>           | <input type="checkbox"/> Awakened at night<br><input type="checkbox"/> Age of onset _____                                       | <input type="checkbox"/> While resting<br><input type="checkbox"/> Relieved by: _____   | <input type="checkbox"/> With exercise  |
| <b>Wheezing/<br/>chest tightness</b> | <input type="checkbox"/> Awakened at night<br><input type="checkbox"/> Every day<br><input type="checkbox"/> Relieved by: _____ | <input type="checkbox"/> 3x or more a week  | <input type="checkbox"/> Once a week <input type="checkbox"/> Once a month  |
| <b>Asthma</b>                        | <input type="checkbox"/> Ever diagnosed?<br><input type="checkbox"/> Admitted to ICU for asthma                                 | <input type="checkbox"/> Oral steroids for asthma   | <input type="checkbox"/> ER visits for asthma ____ <input type="checkbox"/> Hospitalized for asthma   |
| <b>Other</b>                         | <input type="checkbox"/> Mouth breathing  | <input type="checkbox"/> Snoring  | <input type="checkbox"/> Frequent bronchitis <input type="checkbox"/> Headaches   |

#### PRIMARY SYMPTOMS ARE WORSE WITH:

- |  |                                   |  |   |                                   |
|--|-----------------------------------|--|---|-----------------------------------|
| <input type="checkbox"/> Spring            | <input type="checkbox"/> Summer   | <input type="checkbox"/> Fall            | <input type="checkbox"/> Winter         | <input type="checkbox"/> All year |
| <input type="checkbox"/> School/work days  | <input type="checkbox"/> Home     | <input type="checkbox"/> Vacations       |   |                                   |
| <input type="checkbox"/> Weather change    | <input type="checkbox"/> Indoors  | <input type="checkbox"/> Outdoors        |   |                                   |
| <input type="checkbox"/> Humidity          | <input type="checkbox"/> Heat     | <input type="checkbox"/> Cold air        | <input type="checkbox"/> Windy days     |                                   |
| <input type="checkbox"/> Tobacco smoke     | <input type="checkbox"/> Perfumes | <input type="checkbox"/> Irritants       | <input type="checkbox"/> Flowers        |                                   |
| <input type="checkbox"/> Cats              | <input type="checkbox"/> Dogs     | <input type="checkbox"/> Horses          | <input type="checkbox"/> Other pets     |                                   |
| <input type="checkbox"/> Moldy/musty areas | <input type="checkbox"/> Dust     | <input type="checkbox"/> Stuffed animals | <input type="checkbox"/> Emotion/stress |                                   |

#### PRIMARY SYMPTOMS ARE BETTER WITH:

- Air conditioning  Travel away from home
- Medication including \_\_\_\_\_
- Other \_\_\_\_\_

#### INFANCY:

- Normal pregnancy/labor/delivery  Abn. pregnancy \_\_\_\_\_  Abn. labor/delivery \_\_\_\_\_
- Breast fed for \_\_\_\_\_ months  Formula fed with \_\_\_\_\_  Colic

#### FAMILY HISTORY:

	Mother	Father	Siblings	Children
<u>Asthma</u>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<u>Allergies/Hayfever</u>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<u>Food Allergy</u>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<u>Drug Allergy</u>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## New Patient Intake Form

### **FOOD ALLERGY:**

- Patient does not have any food allergy or intolerance.  
 Patient has allergic or adverse reactions to:
- |  |                                    |                                |  |
|--|------------------------------------|--------------------------------|--|
| <input type="checkbox"/> Milk  | <input type="checkbox"/> Egg       | <input type="checkbox"/> Wheat | <input type="checkbox"/> Soy                     |
| <input type="checkbox"/> Peanut  | <input type="checkbox"/> Tree nuts | <input type="checkbox"/> Fish  | <input type="checkbox"/> Shellfish               |
| <input type="checkbox"/> Patient has had a life threatening reaction to: _____ |                                    |                                | <input type="checkbox"/> Patient has an Epi-Pen. |

### **DRUG ALLERGY: Please check box if patient has had any allergic or adverse reactions to these medications:**

- |   |   |
|---|---|
| <input type="checkbox"/> Penicillin, Amoxicillin, Ampicillin            | <input type="checkbox"/> Cephalosporins (Ceclor, Ceftin, Cefzil, Keflex, Omnicef, etc)                |
| <input type="checkbox"/> Erythromycin (i.e. E-mycin, Biaxin, Zithromax) | <input type="checkbox"/> Sulfa-based antibiotics (Bactrim, Septra)                                    |
| <input type="checkbox"/> Tetracycline (i.e. Doxycycline, Minocycline)   | <input type="checkbox"/> Quinolones (i.e. Cipro, Levaquin, Avelox)                                    |
| <input type="checkbox"/> Aspirin  | <input type="checkbox"/> Non-steroidal anti-inflammatory drugs (i.e. Motrin, Advil, Ibuprofen, Aleve) |
| <input type="checkbox"/> Decongestants (i.e. Sudafed)                   |   |
| <input type="checkbox"/> Other _____                                    |   |

### **RECURRENT AND CHRONIC INFECTIONS:**

- |  |  |
|--|--|
| <input type="checkbox"/> Frequent sinus infections. How many per year? _____                           | <input type="checkbox"/> Sinus surgery. When? _____              |
| <input type="checkbox"/> Frequent ear infections. How many per year? _____                             | <input type="checkbox"/> Ear tubes have been placed. When? _____ |
| <input type="checkbox"/> Pneumonia <input type="checkbox"/> X-ray did show pneumonia                   | <input type="checkbox"/> Bone or joint infections                |
| <input type="checkbox"/> Abscesses of skin or frequent skin infections or abscesses of internal organs |  |

### **SOCIAL AND ENVIRONMENTAL HISTORY:**

- Main residence:**  Single family home     Townhouse     Apartment/Condo     Trailer  
Number of years lived in present home? \_\_\_\_\_  
Age of home? \_\_\_\_\_  
 In a woody place     In a sunny place  
 Previous owners had:  Dog     Cat  
 Fireplace     Wood stove     Smoker (s) in house  
Bath soap \_\_\_\_\_ Shampoo \_\_\_\_\_ Laundry detergent \_\_\_\_\_  Dryer sheets are used.
- Home heating:**  Central gas forced air     Central electric forced air     Central gas and electric     Oil fired hot water heating  
 Baseboard heat     Radiator heat
- Central electrostatic air filter     Central electronic air filter  
 Filter is changed regularly     Filter is washed regularly
- Home flooring:**  Mostly wall to wall carpeting     Mostly hard surface flooring (wood, tile, linoleum, etc)
- Pets:**  Cats \_\_\_\_\_     Dogs \_\_\_\_\_     Birds     Hamsters/Gerbils
- Pests:**  Mice     Cockroaches
- Patient's bedroom:**  
 Wall to wall carpet     Curtains     Blinds  
 Humidifier     Ceiling fan     HEPA filter  
 Stuffed animals     Stuffed animals in bed     Stuffed animals washed regularly  
 Dog enters bedroom     Dog sleeps on bed     Cat enters bedroom     Cat sleeps on bed  
 Regular mattress     Feather mattress     Feather pillow     Bunk Bed  
Dust mite/allergen proof covers are on:  Mattress     Pillows     Boxspring

### **PREVIOUS ALLERGY EVALUATIONS/TREATMENTS:**

- Have you been skin tested for allergies?  What year? \_\_\_\_\_ Where? \_\_\_\_\_  
Have you had blood tests for allergies?  What year? \_\_\_\_\_  
Have you taken allergy shots?  When? \_\_\_\_\_ How long? \_\_\_\_\_  Shots helped     Shots did not help  
Patient would like to receive allergy shots  again     for the first time.

### **CURRENT AND PAST MEDICAL PROBLEMS:**

- Patient has no other active or past medical problems.     \_\_\_\_\_  
 \_\_\_\_\_     \_\_\_\_\_

### **CURRENT AND PREVIOUS MEDICATIONS:**

- |                                |                                |                                |
|--------------------------------|--------------------------------|--------------------------------|
| <input type="checkbox"/> _____ | <input type="checkbox"/> _____ | <input type="checkbox"/> _____ |
| <input type="checkbox"/> _____ | <input type="checkbox"/> _____ | <input type="checkbox"/> _____ |

\*\*\* **Please bring ALL current medications with you to your appointment.** \*\*\*