Patient Name ______ Date of Birth ______ Today's Date ______

Houston Pediatric Pulmonary and Sleep Associates

New Patient Questionnaire - Pulmonary & Sleep

Birth History

What hospital/birth center? ______

C-section or vaginal delivery? ◯ c-section ◯ vaginal

What was the birth weight? ______

What was the baby's gestational age at birth? ______

How long was the baby in the hospital? ______

Please list any problems/complications:

______

Past Medical History

Please list the patient's current medical problems: ☐ None

______

Please list all surgeries in the patient's lifetime: ☐ None

Surgery:	Date:	Surgeon:

Please list the patient's current medications (if additional room is needed, please provide attached list): ☐ None

Name: ☐ See attached.	Frequency/Dose/Strength:

Please list any allergies (medication, food, other): ☐ None

______

Please list any other medical specialists the patient has seen (ENT, allergist, cardiologist, etc.)

______

Please list how many times the patient has had/done the following (in the **past 1 year** of life or in the patient's **entire life**):

	Past Year:	Life:
Had an urgent visit to the doctor		
Went to the emergency room		
Admitted to the hospital		
Admitted to the ICU		
Intubated		
Taken a course of oral (by mouth) steroids		
Taken a course of antibiotics		

How many days of school did the patient miss in the last year for illness?

______

What is the name of your current home health care company?

______

Please list any special home medical equipment (oxygen, feeding pump, apnea monitor, etc.)

______

Family History

Please list the patient's siblings: ☐ None

Name:	Birth Date:	Gender:
		◯ M ◯ F
		◯ M ◯ F
		◯ M ◯ F
		◯ M ◯ F
		◯ M ◯ F

Are there any medical problems in the family? Be sure to include any breathing, sleeping or psychiatric problems.

Family Member	Disease/Problem ☐ None

Patient Name ____ Date of Birth ____ Today's Date ____

Social History

Does patient attend any type of daycare? ☐ Yes ☐ No

Does anyone the patient knows smoke? ☐ Yes ☐ No

Please list any pets in the home, or other animals to which the patient is exposed. ☐ None

____

Do any of the pets sleep with the patient? ☐ Yes ☐ No

Does the patient share a bedroom with anyone? ☐ Yes ☐ No

Does the patient share the bed with anyone? ☐ Yes ☐ No

Who lives with the patient at home?

____

Are there any problems with the conditions of the patient's home (water damage, mold, insects, pests, peeling paint)? Explain: ☐ Yes ☐ No

____

How often are the air conditioning filters changed? ____

What grade is the patient currently in? ____

What sports does the patient play currently?

____

What other hobbies or activities is the patient involved in currently?

____

Does the patient live close to any industrial refineries, chemical factories, or other industrial plants? ☐ Yes ☐ No

Does the patient's bedroom have:

Carpet	☐ Yes	☐ No
Curtains	☐ Yes	☐ No
Ceiling fan	☐ Yes	☐ No
Stuffed animals	☐ Yes	☐ No

Sleep History

Please answer for both, **S**chool **N**ights (**SN**) and **W**eek**e**nds (**WE**), for each question.

	SN:	**WE:**
What time does the patient go to bed?	____	____
How long does it take for the patient to fall asleep?	____	____
At what time does the patient wake up to start their day?	____	____
How many times does the patient wake up throughout the night?	____	____
How many naps does the patient take during the day?	____	____
How long is each nap?	____	____

Patient Name ☐ Date of Birth ☐ Today's Date ☐

Review of Systems

Constitutional

Fever (recent, or recurrent)	☐ Yes	☐ No
Night sweats	☐ Yes	☐ No
Weight ○ loss or ○ gain	☐ Yes	☐ No
Decreased energy	☐ Yes	☐ No
Appetite changes	☐ Yes	☐ No
Difficulty gaining weight	☐ Yes	☐ No

Eye

Itchy eyes	☐ Yes	☐ No
Watery eyes	☐ Yes	☐ No
Red eyes	☐ Yes	☐ No
Vision Problems	☐ Yes	☐ No

Ear, Nose, Mouth, & Throat

Runny nose	☐ Yes	☐ No
Nasal congestion	☐ Yes	☐ No
Frequent sinus infections	☐ Yes	☐ No
Frequent sniffing or sneezing	☐ Yes	☐ No
Frequent throat clearing	☐ Yes	☐ No

Cardiovascular

Heart murmur or heart problem	☐ Yes	☐ No
Chest pain	☐ Yes	☐ No
Exercise limitation	☐ Yes	☐ No
Fainting Spells	☐ Yes	☐ No

Gastrointestinal

Vomiting or excessive spit up	☐ Yes	☐ No
Constipation	☐ Yes	☐ No
Heart burn	☐ Yes	☐ No
Frequent abdominal pain	☐ Yes	☐ No
Frequent burping	☐ Yes	☐ No
Frequent hiccups	☐ Yes	☐ No
History of iron or other nutritional deficiency	☐ Yes	☐ No

Endocrine

Too hot or too cold	☐ Yes	☐ No
Blood sugar problems (including diabetes)	☐ Yes	☐ No
Easy bruising	☐ Yes	☐ No
Take birth control pills	☐ Yes	☐ No

Other

Please note any other important symptoms not listed above:

Neurological

Frequent headaches	☐ Yes	☐ No
Convulsions or seizures	☐ Yes	☐ No
Developmental delays	☐ Yes	☐ No
Is or was your child enrolled in ECI?	☐ Yes	☐ No
Does your child require special classes in school?	☐ Yes	☐ No
Does your child require therapy?	☐ Yes	☐ No

If yes, please identify
○ Speech ○ Language ○ Physical ○ Occupational

Sleep - Daytime

Hyperactive	☐ Yes	☐ No
Difficulty focusing/concentrating	☐ Yes	☐ No
Irritability	☐ Yes	☐ No
Defiant	☐ Yes	☐ No
Dry mouth in the morning	☐ Yes	☐ No
Too sleepy during the day	☐ Yes	☐ No
Falls asleep at inappropriate times	☐ Yes	☐ No

Sleep - Nighttime

Snores more than 3 nights per week	☐ Yes	☐ No
Episodes where patient stops breathing while sleeping	☐ Yes	☐ No
Chokes/gags/gasps/snorts while sleeping	☐ Yes	☐ No
Kicks legs while asleep	☐ Yes	☐ No
Body movements while asleep	☐ Yes	☐ No
Sleep walking	☐ Yes	☐ No
Sleep talking	☐ Yes	☐ No
Has difficulty falling asleep	☐ Yes	☐ No
Teeth grinding	☐ Yes	☐ No
Bed wetting	☐ Yes	☐ No

Psychiatric

Symptoms of anxiety (excessive worries)	☐ Yes	☐ No
Symptoms of depression (hopeless, helpless, excessive sadness, crying)	☐ Yes	☐ No
Behavioral problems (fighting at school)	☐ Yes	☐ No
Other psychiatric conditions	☐ Yes	☐ No

Allergic/Immunologic

Eczema (dry, rough, or itchy skin)	☐ Yes	☐ No
Hives (urticaria)	☐ Yes	☐ No
Allergies (allergic rhinitis, hay fever, etc.)	☐ Yes	☐ No