Duke Pediatric Pulmonary and Sleep Medicine: New Patient Questionnaire:

This information will help your doctor or nurse practitioner in the PPL clinic. Please answer all questions to the best of your ability and bring the form with you. All questions apply only to the patient.

Patient Information:

Name of patient: _____ MRN _____ Date of birth: _____

Name of parent/guardian: _____

Address: _____

Phone: 1. _____ (cell/ home) 2. _____(cell/home/work)

Email address(es): _____

Primary care provider: _____ Who referred the patient? _____

Main concern:

In your own words your main concern: **Please describe symptoms in detail: when they began (date or age), how long they last, whether they have changed, and what symptoms are present now:**

_____

_____

_____

_____

What seems to trigger the symptoms? _____

What has seemed to help? _____

_____

Are symptoms present during the day **and** at night? Which is worse? _____

What, if any, symptoms are present during exercise? _____

Current Medications if any

List all medications the patient is **currently taking** (include vitamins/herbs/ and over the counter med):

_____ _____

_____ _____

_____ _____

_____ _____

Past Medical History:

Born : ___ full term ___ premature-- if so, how premature and why? _____

Birth wt: _____ Any problems at birth: _____

Any problems or health issues in first year of life: _____

_____

Childhood illnesses:_____

_____

Any history of surgeries or hospitalizations, why? And when? _____

_____

Has he/she ever had a chest xray or other radiology study?: ____ if yes, what and when _____

_____

List any allergies your child has, including food allergies, medication allergies, or seasonal allergies. In each case, how does he/she react (hives/rash/respiratory issues, etc:

_____

_____

Have immunizations been given? _____ Are they up to date? _____

If not given, why? _____

Family History:

Is there any history of respiratory illnesses, asthma, allergies, or communicable illnesses in your family---father/mother/ siblings/ grandparents/ aunts/ uncles/cousins

_____

_____

Social/Environmental History:

Do you live in a house or apartment or condo? _____ Do you have a basement? _____

Do you have pets? ____ if so, what? _____ Indoor or outdoor? _____Has child had problems around pets? _____ Does anyone smoke? _____ if so, who? _____Where? _____

Is the patient in school or daycare? _____what grade? _____ Does he/she take PE: _____

Review of systems: Circle any problems the patient ***currently*** has trouble with. If your child has had any of these concerns in the past, note that at the bottom, if you haven't already noted it earlier

General	**Neck**	**Abdomen**	**Nervous sys**
Fever	Trouble swallowing	**Stomach aches**	Seizures/tics
Weight change	Enlarged lymph nodes	**Reflux**	Clumsiness
Appetite issue		Heart-burn	Confusion
Sleep issues	**Chest/Lungs**	Diarrhea	
Snoring	**Pneumonia**	**Bulky stools**	**Development**
	Bronchitis	**Foul smelling stools**	Growth issues
HENT	**Cough**	Constipation	Delay
Headaches	**Wheezing**		School problems
Nasal congestion	**Croup**	**Genitourinary**	Behavior problems
Sinus infection	**Chest pain**	Urinary tract infection	
Ear infections	**Chest tightness**	Blood in urine	**Immune system**
Cavities	**Trouble exercising**	Painful urination	**Frequent infections**
		Menstrual problems	**Hives**
Eyes	**Heart**		
Vision problems	Congenital problems	**Musculoskeletal**	**Skin**
Eye infection	High blood pressure	Weakness	**Eczema**
Redness or drainage	Heart racing	Pain or swelling	**Rashes**
		Joint pain	Nailbed clubbing
Other:			

Note: _____

_____