NAME:_____ AGE:_____

Date of Appointment:_____ ID (For Office Use Only):_____.

## NEW PATIENT HISTORY (Children 11 and Younger)

Person completing the form: _____

Referred by: _____

What are your main concerns today? _____

_____

Lung function tests are adjusted based on race for accuracy. Please indicate which item best describes you (the patient):
__ African American __ Native American __ Asian __ Caucasian __ Hispanic __ Other

### Medication List:

_____
_____
_____
_____
_____
_____
_____
_____
_____

### Nasal Allergy

Are you having (allergy) eye, ear, nose, or throat problems: __ Yes __ No
How many years have you had symptoms? ____
What are your primary symptoms? _____
_____

### Food Allergy

Have food allergies been a problem: __ Yes __ No
List foods that are suspicous for allergy: _____

### Hives

Have hives been a problem: __ Yes __ No

Hives began: _____
Hives appear to be triggered by: _____

**Do you have any current medical problems?**
__ No known problem

Current problems: _____

_____

_____

_____

_____

## Immunizations

| | | | |
|---|---|---|---|
| Routine childhood immunizations are up to date: | __ Yes | __ No | __ I don't know |
| Received Pneumovax (Pneumonia vaccine): | __ Yes | __ No | __ I don't know |
| | Month/Year _____ | | |
| Tetanus in last ten years: | __ Yes | __ No | __ I don't know |
| Flu shot in the past year: | __ Yes | __ No | __ I don't know |
| | Month/Year _____ | | |

## Medication Allergies

__ No Known Drug Allergies
Current Medicatino Allergies: _____
_____
_____
_____
_____
_____

## Surgical History

Please indicate if you have had any of the following surgeries
__ I have had no surgeries
_____
_____
_____
_____
_____

## Family Medical History (List Conditions)

Mother:_____

Father:_____

Siblings:_____

## Social History

Marital Status: __ Single __ Married __ Divorced/Separated __ Widow(er)
Smoking Status: __ current every day smoker
__ current some day smoker
__ former smoker
__ never smoker
__ unknown if ever smoked
__ smoker – current status unknown
Smoking type: __ Cigar __ Cigarettes __ Pipe __ E-Cigs __ Vaping
Smoking duration: __ N/A __ 1-5 years __ 6-10 years __ 11-20 years __ over 20 years
Maximum packs per day: __ ½ __ 1 __ 1 ½ __ 2 or more
Alcohol: __ Never __ Rarely __ Weekly __ Daily
Do you primarily work: __ Indoors __ Outdoors
Occupation: _____
Other: _____

Pediatric Patients
Child attends: __ Daycare __ Preschool __ School __ Home school __ None
Does child have any
brothers or sisters: __ Yes __ No
Other: _____

## Environmental History

Pets/animals (Indoor): __ None
_____
Pets/animals (Outdoor): __ None
Smoke Exposure?_____
Other Concerning Exposures?_____

## IF YOU ARE NOT HERE FOR ASTHMA RELATED SYMPTOMS PLEASE DO NOT COMPLETE

**Please answer yes or no to each of the following:**
ER visits for asthma in past year: ___Yes ___ No How many in past year: _____
Hospitalized for asthma in past year: ___ Yes ___ No How many in past year: _____
Intensive care unit for asthma: ___ Yes ___ No
Does patient have peak flow meter: ___ Yes ___ No
Had a chest X-ray in the past year: ___ Yes ___ No
If yes: ___ Normal ___ Abnormal
Steroid (Prelone, Pediapred, Prednisone, steroid shots) bursts in past year: __ 0 __ 1-2 __ 3-5 __ 6-10 __ over 10

**IF YOU ARE NOT HERE FOR ASTHMA RELATED SYMPTOMS PLEASE DO NOT COMPLETE**

## Patient is 4-11 years old (Please have child answer next 4 questions)

How is your asthma today:

___ Very bad
___ Bad
___ Good
___ Very good

How much of a problem is your asthma when you run, exercise, or play sports:

___ It's a big problem – I can't do what I want to do
___ It's a problem and I don't like it
___ It's a little problem but it's OK
___ It's not a problem

Do you cough because of your asthma:

___ Yes – all of the time
___ Yes – most of the time
___ Yes – some of the time
___ No - none of the time

## During the past 4 weeks, on average, how many days(Answer by parent or care giver)

Did your child have any daytime asthma symptoms:

___ None
___ 1-3 days/month
___ 4-10 days/month
___ 11-18 days/month
___ 19-24 days/month
___ every day

Did your child wheeze during the day because of asthma:

___ None
___ 1-3 days/month
___ 4-10 days/month
___ 11-18 days/month
___ 19-24 days/month
___ every day

Did your child wake up during the night because of asthma:

___ None
___ 1-3 days/month
___ 4-10 days/month
___ 11-18 days/month
___ 19-24 days/month
___ every day