



PULMONARY QUESTIONNAIRE

Patient's Name:

Date of Birth:

Address:

Phone:

Pediatrician:

Phone:

Address:

Fax:

1. What problem brought you and your child to the doctor today?

2. How long has he/she had these symptoms?

3. Place an "X" if your child has had any of the following:

- | | |
|--|--|
| <input type="checkbox"/> Persistent Cough | <input type="checkbox"/> Snoring |
| <input type="checkbox"/> Barking Cough | <input type="checkbox"/> Weight Loss |
| <input type="checkbox"/> Cough when Drinking/Eating | <input type="checkbox"/> Poor Weight Gain |
| <input type="checkbox"/> Noisy Breathing | <input type="checkbox"/> Poor Growth |
| <input type="checkbox"/> Wheezing | <input type="checkbox"/> Poor Development (Slow) |
| <input type="checkbox"/> Wheezing with Exercise | <input type="checkbox"/> Frequent Headaches |
| <input type="checkbox"/> Rattling Noise in the Throat | <input type="checkbox"/> Frequent Sinus Infections (More than 3) |
| <input type="checkbox"/> Rattling Noise in the Chest | <input type="checkbox"/> Frequent Ear Infections (More than 3) |
| <input type="checkbox"/> Hoarseness | <input type="checkbox"/> Nose Runs Often |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Nose Itches Often (Rubs Nose) |
| <input type="checkbox"/> Bronchiolitis | <input type="checkbox"/> Eyes Itch Often |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Eyes Get Red |
| <input type="checkbox"/> Difficulty Breathing | <input type="checkbox"/> Eyes Get Teary |
| <input type="checkbox"/> Apnea (Stop Breathing) | <input type="checkbox"/> Eyes Get Swollen |
| <input type="checkbox"/> Foul Breath | <input type="checkbox"/> Blue Circle Under the Eye |
| <input type="checkbox"/> Distended Abdomen | <input type="checkbox"/> Eczema |
| <input type="checkbox"/> Excessive Gas | <input type="checkbox"/> Skin Rashes |
| <input type="checkbox"/> Frequent Abdominal Pain (Belly Aches) | <input type="checkbox"/> Other: |
| <input type="checkbox"/> Frequent Vomiting | |
| <input type="checkbox"/> Vomits when Drinking | |
| <input type="checkbox"/> Food Allergy | |



4. Does exposure to any of the following make your child's symptoms appear or get worse?

- | | |
|---|--|
| <input type="checkbox"/> Weather Changes | <input type="checkbox"/> Insecticides |
| <input type="checkbox"/> Temperature Changes (Hot to Cold or Cold to Hot) | <input type="checkbox"/> Chemicals |
| <input type="checkbox"/> Rainy Days | <input type="checkbox"/> Fumes |
| <input type="checkbox"/> Foggy Days | <input type="checkbox"/> Aerosols |
| <input type="checkbox"/> House Cleaning | <input type="checkbox"/> Perfumes |
| <input type="checkbox"/> Recently Mowed Lawn | <input type="checkbox"/> Cosmetics |
| <input type="checkbox"/> Excitement/Anger | <input type="checkbox"/> Cigarette Smoke |
| <input type="checkbox"/> Physical Exertion | <input type="checkbox"/> Infection (Virus), Colds, Flu |
| <input type="checkbox"/> Being Around Animals | <input type="checkbox"/> Specific Foods |

5. Bowel Movements: Normal Abnormal (If abnormal, please place an "X" below)

- | | | |
|---|--|---------------------------------|
| <input type="checkbox"/> Very Foul Smelling | <input type="checkbox"/> Large | <input type="checkbox"/> Float |
| <input type="checkbox"/> Very Pale | <input type="checkbox"/> Loose or Diarrhea | <input type="checkbox"/> Greasy |
| <input type="checkbox"/> Very Hard | <input type="checkbox"/> Very Infrequent (Constipated) | |
| <input type="checkbox"/> Other: | | |

6. Are your child's immunizations (baby shots) up to date? Yes No

7. Basic History:

- A. Birth Weight: _____ Present Weight: _____
- B. Pregnancy: Normal Abnormal (explain): _____
- C. Delivery: Normal Abnormal (explain): _____
- D. Full Term? Yes No If premature, how premature? _____
- E. Problems during the newborn period? Yes No
If yes, explain: _____

8. Has your child ever been hospitalized? Yes No If yes:

<u>Reason</u>	<u>Date</u>	<u>Hospital</u>

9. Has your child ever seen a specialist for other problems? Yes No
If yes, name: _____

10. Has your child had allergy testing? Yes No When? _____
By whom? _____



11. Has your child had chest x-rays? Yes No When?
By whom?

12. Has your child taken any medication? Yes No (Complete Below)

Name of Medication	Reason

13. Place an "X" if any family members (grandparents, cousins, aunts, uncles, brothers, sisters) have had any of the following:

Condition	Relationship	Condition	Relationship
<input type="checkbox"/> Allergy		<input type="checkbox"/> Asthma	
<input type="checkbox"/> Hay Fever		<input type="checkbox"/> Diabetes (sugar)	
<input type="checkbox"/> Cystic Fibrosis		<input type="checkbox"/> Tuberculosis	
<input type="checkbox"/> Cancer		<input type="checkbox"/> Heart Disease	
<input type="checkbox"/> Anemia		<input type="checkbox"/> Bronchitis/Emphysema	
<input type="checkbox"/> Liver Disease		<input type="checkbox"/> Hemophilia/Bleeding	
<input type="checkbox"/> Digestive Disorder		<input type="checkbox"/> SIDS	
<input type="checkbox"/> Eczema		<input type="checkbox"/> Sickle Cell Disease	

14. Father: Age Occupation:
Smoker? Yes No How much?

15. Mother: Age Occupation:
Smoker? Yes No How much?

16. Are there any other children in the patient's family? Yes No

Name	Age	Date of Birth	Health Problems



Race and Ethnicity Information

We want to make sure that all our patients get the best care possible. We would like you to tell us your child's racial and ethnic background as well as your preferred language so that we can review the treatment that all patients receive and make sure that everyone gets the highest quality of care. You may decline to answer if you wish.

The only people who see this information are registration staff, administrators for the practice, your care providers, and the people involved in quality improvement and oversight, and the confidentiality of what you say is protected by law.

Please mark the appropriate response:

Primary Language

- | | | | |
|---|---|--|-----------------------------------|
| <input type="checkbox"/> Albanian | <input type="checkbox"/> American Sign Language | <input type="checkbox"/> Arabic | <input type="checkbox"/> Armenian |
| <input type="checkbox"/> Bengali | <input type="checkbox"/> Bosnian | <input type="checkbox"/> Cantonese (Chinese) | |
| <input type="checkbox"/> Creole | <input type="checkbox"/> Croatian | <input type="checkbox"/> ECH | <input type="checkbox"/> Danish |
| <input type="checkbox"/> English | <input type="checkbox"/> French | <input type="checkbox"/> German | <input type="checkbox"/> Greek |
| <input type="checkbox"/> Hebrew | <input type="checkbox"/> Hindi | <input type="checkbox"/> Indonesian | <input type="checkbox"/> Italian |
| <input type="checkbox"/> Japanese | <input type="checkbox"/> Korean | <input type="checkbox"/> Latin | <input type="checkbox"/> Malay |
| <input type="checkbox"/> Mandarin (Chinese) | | <input type="checkbox"/> Persian | <input type="checkbox"/> Polish |
| <input type="checkbox"/> Portuguese | <input type="checkbox"/> Romanian | <input type="checkbox"/> Russia | <input type="checkbox"/> Serbian |
| <input type="checkbox"/> Slovak | <input type="checkbox"/> Spanish | <input type="checkbox"/> Swahili | <input type="checkbox"/> Swedish |
| <input type="checkbox"/> Tagalog | <input type="checkbox"/> Thai | <input type="checkbox"/> Turkish | <input type="checkbox"/> Urdu |
| <input type="checkbox"/> Vietnamese | <input type="checkbox"/> Yiddish | <input type="checkbox"/> Yugoslavian | <input type="checkbox"/> Other |
| <input type="checkbox"/> Declined | <input type="checkbox"/> Unknown | | |

Race

- | | |
|---|--|
| <input type="checkbox"/> American Indian or Alaska Native | <input type="checkbox"/> Asian |
| <input type="checkbox"/> Black or African American | <input type="checkbox"/> Native Hawaiian or Other Pacific Island |
| <input type="checkbox"/> White | <input type="checkbox"/> Other Combination Not Described |
| <input type="checkbox"/> Declined | |

Ethnicity

- Hispanic or Latino or Spanish Origin
- Not Hispanic or Latino or Spanish Origin
- Declined



Pharmacy Information

So that you and your physician may take advantage of e-prescribing, we need you to provide information on the pharmacy that you choose to use to fill you or your child's prescriptions. Electronic prescription requests are more efficient, accurate and cost effective. Feel free to speak with your physician if you have additional questions.

New

Date:

Patient Name:

NYH #:

PRIMARY

Pharmacy Name:

Address:

Phone Number:

Fax Number:

SECONDARY (if applicable)

Pharmacy Name:

Address:

Phone Number:

Fax Number: