PEDIATRIC PULMONARY NEW PATIENT FORM- DR. WAN C. TSAI

Visit date: _____

Child's name: Last _____, First _____ Middle initial _____

DOB: _____ Age (in years and nearest months):_____

Primary Care Doctor: _____ Referring doctor: _____

Please indicate what problems your child has been referred for evaluation of:

PAST MEDICAL HISTORY

Birth history: What # baby for mother ____.

Was baby born prematurely? ___Yes ___No; if yes, gestational age ____weeks.

Birth weight _____ pounds _____ ounces;

Age of mother at time of baby's birth ___-year-old;

Complications during pregnancy _____

Circle whether vaginal / C-section delivery; Complications during delivery _____

Parental screen: Parents screened for any conditions (cystic fibrosis) prior to baby's birth? ___Yes ___No; _____

Newborn screen: Baby positive for any of the conditions screened at birth? ___Yes ___No;

Neonatal history: Baby stayed more than 2 days in nursery? ___Yes ___No;

Complications during stay? Please list: _____

If premature, how long was baby in NICU? _____

Was baby on breathing machine/ventilator? ___Yes ___No; If yes, how long? _____

Did baby transitioned to other breathing support like CPAP etc? ___Yes ___No; Please list _____. If yes, how long? _____

Was baby on oxygen? ___Yes ___No; If yes, how long? _____

Complications during NICU stay? Please list: _____

Feeding history:

Was baby breast fed ? ___Yes ___No If yes, how long? _____

Was baby bottle fed? ___Yes ___No If yes, list type of formula? _____

Did baby have vomiting and diarrhea tolerating formula? ___Yes ___No. If yes, how did symptoms resolved? _____

_____.

Did the baby spit up excessively ___Yes ___No; very colicky ___Yes ___No;

Any difficulties with feeding? ___Yes ___No; If yes, please list _____

Current problems with eating, diet? ___Yes ___No; If yes, please list _____

Developmental milestones

Any known delayed developmental milestones? _____

RESPIRATORY HISTORY (Please list all respiratory events in chronological order)

Date (at least season/year)	Age	what symptoms did child have	Diagnoses	Intervention/what was done for child

REVIEW OF SYSTEMS Has your child had any of the following problems?

Cough (at baseline, when "well")

Cough productive of sputum ___Yes ___No
During daytime ___Yes ___No
During nighttime ___Yes ___No
Awakens child up at night ___Yes ___No
Relieved with bronchodilators? ___Yes ___No
Relieved with steroids? ___Yes ___No
Cough occurs only with illness ___Yes ___No
Cough even when well ___Yes ___No if yes, how many times a week _____or a month _____

Wheezing (at baseline, when "well")

During daytime ___Yes ___No
Nighttime ___Yes ___No
Awakens child up at night ___Yes ___No
Relieved with bronchodilators? ___Yes ___No
Relieved with steroids? ___Yes ___No
Wheeze occurs only with illness ___Yes ___No
Wheeze even when well ___Yes ___No if yes, how many times a week _____or a month _____

Illness

Exacerbations are characterized by _____triggered by_____

How many oral steroid courses has child received over lifetime _____ or over the last year _____

Rescue bronchodilators are used ___Yes ___No

Other respiratory symptoms

Chest pain ___Yes ___No
Exercise intolerance ___Yes ___No; if yes, what symptoms with exercise _____
Shortness of breath ___Yes ___No
Cyanosis/turning blue ___Yes ___No
Breath holding spells ___Yes ___No; if yes, central or obstructive apneas? _____
Snoring ___Yes ___No; if yes, does child stop breathing with snoring? _____
Snorting/stertor ___Yes ___No
Stridor ___Yes ___No
Restless sleep ___Yes ___No

Respiratory infections: If yes to any of the below, please list how frequently (# in lifetime, # per year)

Ear infections ___Yes ___No _____
Colds/upper respiratory infections ___Yes ___No _____
Sinusitis ___Yes ___No _____
Bronchitis ___Yes ___No _____
Pneumonias ___Yes ___No _____

Allergic symptoms:

Did baby have infantile eczema? ___Yes ___No; If yes, at what age did eczema begin? _____ months old.
Rashes ___Yes ___No; If yes, ____all year round? _____seasonal?
Sniffles ___Yes ___No; If yes, ____all year round? _____seasonal?
Sneezing ___Yes ___No; If yes, ____all year round? _____seasonal?
Clear runny nose ___Yes ___No; If yes, ____all year round? _____seasonal?
Stuffy nose ___Yes ___No; If yes, ____all year round? _____seasonal?
Itchy, rubbing or picking nose ___Yes ___No; If yes, ____all year round? _____seasonal?

Other nasal symptoms _____

Itchy eyes ___Yes ___No; If yes, ____all year round? _____seasonal?
Water eyes ___Yes ___No; If yes, ____all year round? _____seasonal?
Headaches ___Yes ___No; If yes, ____all year round? _____seasonal?
Facial tenderness ___Yes ___No; If yes, ____all year round? _____seasonal?

Seasonality ___Yes ___No; If yes, please list _____

Has child seen an allergist? ___Yes ___No; If yes, Allergist: _____

Has child had allergy testing? ___Yes ___No; If yes, please circle: intradermal, skin prick, RAST blood test

Age at time of testing _____

Please list all allergen(s) to which child is reactive?

_____

Heartburn ___Yes ___No
Abdominal pain ___Yes ___No
Foreign body aspiration ___Yes ___No

PAST SURGICAL HISTORY

Has your child had an operation? ___Yes ___No If yes, please list in chronological order.

Date	Age	What procedure was done for child	What condition did child have

FAMILY HISTORY

Is there a history of the following problems in your family (brother/sister, parent, aunt/uncle, grandparent)? If yes, please write relationship.

Asthma ___Yes ___No _____
Hay fever ___Yes ___No _____
Severe allergies ___Yes ___No _____
Chronic lung disease ___Yes ___No _____
Cystic fibrosis ___Yes ___No _____
Failure to Thrive ___Yes ___No _____
Lactose Intolerance ___Yes ___No _____
Celiac disease ___Yes ___No _____
Inflammatory bowel disease ___Yes ___No _____
Immunodeficiencies ___Yes ___No _____
Hearing loss ___Yes ___No _____

Others _____

SOCIAL HISTORY

Who lives in household? _____

Number of brothers (and ages)_____ Sisters (and ages) _____

Parents: _____Married _____Separated _____Never Married

Mother's occupation _____ Father's occupation _____
Do parents bring home unusual dusts and fumes? ___Yes ___No
Known TB exposure? ___Yes ___No Recent travel abroad? ___Yes ___No
How old is your home? _____ Type of heating in the home _____.
Pets _____ indoors _____ outdoors _____.

Did mother smoke while pregnant? ___Yes ___No If yes, how many cigarettes per day? _____
Any smokers in the house now? ___Yes ___No
Outside the house ___Yes ___No
In the car ___Yes ___No
Is there significant secondary smoke exposure in the immediate home? ___Yes ___No
Is child cared for during day in an environment where adults smoke? ___Yes ___No
Can you attribute any increase in child's symptoms with smoke exposure? ___Yes ___No

ALLERGIES: Any adverse reaction to foods or medications _____

IMMUNIZATIONS: up to date? ___Yes ___No; including:
Influenza vaccination ___Yes ___No, if yes, when _____
Pneumococcal vaccine ___Yes ___No, if yes, when _____
Other lung-specific vaccines _____
Any reactions to immunizations? ___Yes ___No; If yes, please list:_____

CURRENT MEDICATIONS

Medication name	Dose	Route (mouth, inhaled, IV, injection)	Times given daily

MEDICAL EQUIPMENT
Durable medical equipment company: _____
Please list all medical equipment () that your child uses:

	Brands/type	How is it given?	How many hours a day?
Nebulizer			
Oxygen			
Apnea monitor			
Others			

Mother's name: Last _____, First _____

Father's name: Last _____, First _____

Child's Address: _____

_____

Home phone: _____ other phone contact: _____

Would you like to be contacted by email? Email address: _____

Please do not write below this line

Physical Exam:
Temperature _____ degrees Fahrenheit, pulse ____ beats per minute, respiratory rate ___ breaths per minute, blood pressure _____ mm Hg, weight _____ kg (%), and height _____ cm (%).
In general, this is an alert child in no apparent respiratory distress.
Skin exam shows rashes.
HEENT exam shows normal cranium, atraumatic.
Extraocular muscles intact. Dennie-Morgan's lines are noted bilaterally, with allergic shiners under the eyes.
Tympanic membranes are bilaterally clear.
Nares note pink normal nasal mucosa, with large inferior turbinates bilaterally.
Oral cavity and posterior pharynx are normal with cobblestoning, and tonsillar hypertrophy.
Neck exam shows lymphadenopathy.
Respiratory movements are symmetrical without use of accessory muscles.
Chest percussion and palpation are normal.
Lungs are clear to auscultation without rales, rhonchi, or wheezes.
Cardiac exam shows regular rate and rhythm without murmurs.
Abdomen is soft, nontender, and nondistended.
Extremities are without clubbing, cyanosis, or edema.
Spine is midline.
Neurologic system is grossly intact.

Spirometry today shows FVC ____L (%), FEV1 ___L (%), FEF_{25-75} ____L/s (%)

Chest X rays were reviewed

Laboratory results were reviewed

Impression
1.
2.
3.
4.

Recommendations
1.
2.
3.
4.

Thank you for allowing us to participate in the care of your patient.
With your permission, we plan to see him her back in _____ months. If there should be any questions, please do not hesitate to contact our office.

Sincerely,

Wan Chong Tsai, M.D., M.S.
Associate Professor
Pediatric Pulmonary

cc: The Family of