PEDIATRIC ASTHMA CONSULT

RESPIRATORY HISTORY QUESTIONNAIRE

(best if completed by patient)

Children's Asthma Center
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Children's Asthma Center
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BACKGROUND INFORMATION **Today's Date:**_____

Name:_____ **Age**: _____ Birthdate: _____ Sex: _____

Home Phone:_____ Cell: _____ Parent Work: _____

Email: _____

Pharmacy of Choice (location included): _____

Mother's Name:_____ Father's Name: _____

Family Doctor: _____ Referring Doctor: _____

Please briefly describe why you were referred or what problem you are having:

_____

-How long have you had this problem? _____Is your problem worsening?_____

MEDICATIONS/INHALERS	Dose	Frequency
May make a separate list		

DRUG ALLERGIES	Reaction

OTHER ALLERGIES	Reaction

SURGICAL HISTORY	Date

DIAGNOSED MEDICAL CONDITIONS (check off)

☐ CANCER	☐ THYROID	☐ CHRONIC SINUS
☐ h/o LUNG/CHEST Trauma	☐ LUNG/TRACHEA Abnormality	☐ CONGENITAL HEART Abnormality
☐ ANEMIA	☐ ARTHRITIS	☐ DIABETES
☐ OBESITY	☐ MIGRAINES	☐ ASTHMA
☐ ARTHRITIS	☐ SEIZURES	☐ ALLERGIES
☐ BROKEN BONES	☐ DEPRESSION	☐ CELIAC DISEASE

GENERAL REVIEW OF SYSTEMS

☐ Fevers/Chills	☐ Anxiety/Stress	☐ Appetite change
☐ Wears glasses	☐ Blurred Vision	☐ Hearing Loss
☐ Mouth-breathing	☐ Bad Breath	☐ Runny Nose
☐ Nausea/Vomiting	☐ Diarrhea	☐ Constipation
☐ Fainting Spells	☐ Heart pounding	☐ Chest Pain
☐ Bedwetting	☐ Frequent Urination	☐ Palate Expander
☐ Braces	☐ Headaches	☐ Weakness
☐ Clumsiness	☐ Muscle/Joint Pain	☐ Hayfever
☐ Rashes	☐ Eczema	❑ Speech Problems
☐ Unexplained weight loss/gain	☐ Frequent Night-time Awakenings	☐ Difficult to wake in the morning
☐ Snoring	☐ Swallowing problem	☐ Heartburn
☐ Feeling depressed	☐ Unexplained Lumps	☐ Easy Bruising/ Bleeding
☐ Leg Cramping	☐ Hyperactivity	☐ Seizures
☐	☐	☐

GROWTH, DEVELOPMENT, NUTRITION

Birthweight _____ ☐vaginal ☐C-Section

Premature? _____ # weeks gestation _____

☐ Complications with pregnancy? ☐ Birth?

☐ Formula/Breast _____ ☐ Solid Foods _____

☐ Nutrition Problems_____

MEDICAL CONDITIONS (additional)

PEDIATRIC RESPIRATORY HISTORY QUESTIONNAIRE—*continued*

HAVE YOU PREVIOUSLY BEEN DIAGNOSED WITH ASTHMA? _____
If yes, at what **age** was he/she diagnosed?
_____

How many times have you been seen in the **emergency room/urgent care** for asthma in the past year?_____

How many times have you been **hospitalized** for asthma in the past year? _____

How many times have you required **oral steroids** in the past year for asthma? _____

Do you have **inhaler** at home? _____
If yes, do you use a **spacer device** with inhaler? _____

QUESTIONS RELATED TO ASTHMA

Please check if you experience any of the following:

- ☐ Wheezing (whistling sounds while breathing)
- ☐ Tightness in your chest
- ☐ Cough
- ☐ Cough, worse particularly at night
- ☐ Shortness of Breath
- ☐ Sputum/Mucus Production
- ☐ Sneezing or itchy, runny nose
- ☐ Red, itchy eyes

ASTHMA TRIGGERS?

- ☐ Exercise or Active Play
- ☐ Cigarette Smoke
- ☐ Animals—*please list*
- ☐ Foods—*please list*
- ☐ Carpets ☐ Chalk Dust ☐ Perfumes
- ☐ Stress ☐ Molds ☐ Pollens
- ☐ Respiratory Infection
- ☐ Unknown Trigger

PREVIOUS ALLERGY TESTING

- ☐ What type Test?
- ☐ When/Where?
- ☐ Results:

WHAT MEDICATIONS HAVE YOU TRIED TO HELP

with Cough	with Shortness of Breath

SLEEP HABITS

1) What time do you usually get in bed for sleep? _____AM/PM
2) How often do you awaken each night?_____
3) Usually wake for the day at _____AM/PM?
4) Indicate the total number of naps per day _____ length____
5) **Avg** hours of sleep at night on week day____ wkend_____

SCHOOL HISTORY

1) Currently in Daycare? _____ Preschool? _____
2) What current or upcoming grade is student in? _____
3) Any concerns about school performance?
   _____
4) Pets in classroom?_____
5) Participate in **sports** or **regular exercise**?_____

WHO LIVES AT HOME?

Name	Age	Relationship

ENVIRONMENTAL HISTORY

☐ Someone in patient's home **smokes**. ☐ In car.
☐ Only **outside smoking**.
☐ **No second-hand smoke exposure**.
☐ **Pets** at home? List: _____
_____
☐ **Mold Exposure?** List:_____
☐ **Concerns** about Home/School/Daycare Environment?
List:_____

FAMILY HISTORY (check all that apply)
Is there a family history of:

	Mother	Father	Brother	Sister	Gparent
APNEA					
SNORING					
ASTHMA					
ALLERGIES					
CYSTIC FIBROSIS					
BIRTH DEFECTS					
SEIZURES					
S.I.D.S.					