Houston Specialty Clinic
Pediatric Neurology | Pediatric Pulmonology | Pediatric and Adult Sleep Medicine
Dr. Joshua Rotenberg, Dr. Sarat Susarla, Kara Schmidt- PA

Pediatric Pulmonary - Medical History

Patient Name: _____ Date of Birth: _____

Has the patient ever been ever been to the Emergency Room? Yes No
If yes, **when** and for **what**?

Has the patient ever stayed overnight in the hospital? Yes No
If yes, **when** and for **what**?

Previously diagnosed medical problems:

Previous surgeries:

Does the patient have any allergies?

Current Medications:

Medications	Dosage	How Often	mg/kg/day

Today's Date: _____

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Birth History:

1. How many weeks pregnant was the mother at the time of birth? _____
2. How much did the infant weigh at birth? _____
3. Was the child born vaginally or by C-section? _____
4. Was child a singleton, twin, or triplet? _____

NICU History

1. Did the child spend any time in the NICU? _____
2. If ***yes***, what was the reason, how long was the stay, and at what hospital?_____
3. Was the child diagnosed with any medical problems while in the NICU? (Yes or No)_____
   If ***yes***, what? _____
4. Any procedures while in the NICU? _____
   If ***yes***, what procedures? _____
5. Was the child on oxygen wither thru a ventilator or a nasal cannula? _____
6. How many days on oxygen? _____

Specialty Questions:

1. Are the patient's immunizations up to dated? _____
2. Has the patient ever received Synagis injections? _____
3. When was the last year the patient received the flu vaccine?_____
4. Has the patient had allergy testing? Yes No
   If ***yes***, where and when? _____
5. Do any of the patient caregivers work in a dusty environment? Yes No

Other information that we need to know?

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Review of Systems

During the past few weeks, have you had any of the following symptoms? Please check all that apply.

Constitutional	○ Fever ○ Fatigue	○ Unexpected weight loss or gain ○ Night sweats	○ Loss of appetite ○ No general complaints	
Sleep:	○ Problems with sleeping ○ Breathing difficulties ○ Excessive sleepiness during the day	○ Dry mouth/sore throat upon awakening ○ Frequent awakening during the night ○ Other sleep difficulties	○ Snoring ○ Choking/gasping during sleep ○ Morning headaches ○ Difficulty falling asleep	○ Excessive movements during sleep ○ No sleeping problems
Eyes:	○ Dry eyes ○ Eye pain	○ Watery eyes ○ Itchy eyes	○ Vision changes	
Ears, Nose, and Mouth	○ Nasal congestion ○ Nasal discharge ○ Ear discharge ○ Bad breath ○ Recurrent strep throat	○ Sinus pressure ○ Nose bleeds ○ Dry mouth ○ Postnasal drip ○ Sensation of fluid or fullness in ear	○ Facial pain ○ Ear pain ○ Tooth pain ○ Nasal ulcers ○ Oral ulcers	○ Sore throat ○ Enlarged tonsils ○ No complaints
Heart:	○ Chest pain ○ Shortness of breath	○ Palpitations ○ Swelling in the legs	○ Racing heart ○ No complaints	
Lungs:	○ Shortness of breath at rest ○ Shortness of breath with exercise	○ Cough with sputum production ○ Blood tinged phlegm or coughing up blood	○ Shortness of breath with normal daily activities ○ Wheezing	○ Cough without sputum production ○ No lung complaints
Stomach and Intestines	○ Nausea ○ Abdominal pain ○ Vomiting	○ Diarrhea ○ Constipation ○ Heartburn	○ Constipation ○ Jaundice ○ Abdominal fullness	○ No complaints
Genito-Urinary System:	○ Painful urination	○ Blood in urine	○ Urgent or frequent urination	○ No complaints
Muscles and Joints:	○ Join pain ○ Muscle aches	○ Joint swelling ○ Muscle weakness	○ Joint stiffness ○ No complaints	
Neurological System:	○ Headaches ○ Vision changes	○ Difficulty with memory ○ Seizures	○ Weakness ○ Tremors	○ Sensory changes ○ No complaints
Psychiatric:	○ Depression	○ Anxiety	○ Panic Attacks	○ No complaints
Hematologic and Lymphatic System:	○ Easy bruising ○ Easy bleeding	○ History of blood clots (DVT) ○ Blood clot antibody	○ Swollen lymph nodes ○ No swollen lymph nodes	○ No complaints
Endocrine and metabolism:	○ Heat intolerance Cold intolerance	○ Frequent need to urinate ○ Always thirsty	○ Intermittent vision changes	○ Problems with thyroid ○ No complaints
Skin:	○ Eczema (dry/itchy skin)	○ Sun Sensitivity ○ Psoriasis	○ Hives ○ Rash	○ No complaints
Allergy and Immunology:	○ Anaphylaxis	○ Angiodema	○ Frequent infections	○ No complaints

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Social History

Please tell us about the patient's environment and social situation. Please check all that apply.

Patient's living environment:

○ House ○ Apartment ○ Trailer home ○ Central A/C ○ Window A/C units ○ Dehumidifier ○ Humidifier	○ Changes air filters regularly ○ Hypoallergenic mattress encasement(s) ○ Stuffed animals in the bedroom	○ Carpet throughout the home ○ Upholstered furniture ○ Drapes/curtains on the windows ○ Hypoallergenic pillow encasements	○ Carpet in the bedroom ○ Mildew/mold problems in the home ○ Wood or leather furniture ○ Blinds on the windows

Does the patient drink alcohol, or is there alcohol consumption in the patient's environment?

○ Daily ○ Less than once a month	○ Weekly ○ Special occasions only	○ Monthly ○ None

Does the patient smoke or is the patient exposed to smoke?

○ Less than 1 pack per day	○ 1 pack per day ○ Greater than 2 packs per day	○ 1-2 packs per day ○ Second hand smoke exposure	○ Snoke exposure in the home/car ○ No smoke exposure

Who lives in the home with the patient?

○ Both parents ○ Siblings	○ Only mom ○ Only dad	○ Spouse ○ Children	○ Foster parent(s) ○ Other

What type of work does the patient (or patient's parents) do?

○ Professional ○ Work in the home	○ Medical field ○ Laboratory work	○ Exposure to toxins and/or chemicals	○ Hard labor ○ Other

Has the patient traveled or lived outside the United States?

○ Yes	○ No

What is the patient's (or patient's parents) marital status?

○ Single	○ Married	○ Divorced	○ Other

Is the patient exposed to pet(s) or animals? If so, how many?

○ Dogs (#)_____ ○ Cats (#)_____	○ Birds (#)_____ ○ Cattle(#)_____	○ Horses (#) _____ ○ No pet/animals

Does the patient attend school?

○ Elementary ○ Middle ○ High School	○ College ○ Not in school	○ Involved in organized sports	○ Does not play sports ○ Involved in extra-curricular activities

Does the patient (or patient's family) have the daycare exposure?

○ Yes	○ No