Pediatric Pulmonary Associates
Patient's Personal History

Patient Name:

Last:_____First:_____Middle:_____

Nickname:_____

Age:_____ Date of Birth:_____

Insurance:_____

Father's name_____ Occupation: _____

Mother's name:_____ Occupation:_____

Primary Care Doctor (First and last name):

_____

Other Specialists involved in care:_____

Pharmacy: _____ Pharmacy Phone #:_____

Pharmacy Address: _____

Medications

List all medications and/or treatments **currently taking:**

_____ _____
_____ _____
_____ _____

List all medications and/or treatments **taken in the past:**

_____ _____
_____ _____
_____ _____
_____ _____

Tests Done

Have any of the following tests been performed?

	DATE	RESULT
____Chest X-Ray	_____	_____
____Allergy Test	_____	_____
____Sweat Test	_____	_____
____Barium Swallow	_____	_____
____Other	_____	_____

Past Medical History

Birth: Gestation _____weeks Birth Wt._____

Describe any complications during pregnancy _____
_____

Describe any complications at birth_____
_____

Number of days in regular nursery _____ or in ICU nursery_____
On ventilator_____on oxygen_____

Development Normal_____Abnormal(explain)_____

List any hospitalizations, reasons, and dates:_____
_____

List any operations and the dates:_____
_____

Please list any other diseases and/or illnesses:_____
_____

Review of Systems

Other Symptoms

___Allergies ___eczema ___stomach aches/symptoms of acid reflux

___Poor growth/obesity ___diarrhea/constipation ___hoarse voice

___Spit-ups/wet burps ___choking with feeds ___snoring

Immunizations

Has received recommended vaccines? Yes___
No___ Reason_____

Previous Flu Vaccine? Yes___ Mo/yr last given_____
No___ Reason_____

Allergies

Drugs: No___ Yes___(explain)_____
Foods: No___ Yes___(explain)_____

Environmental: No___ Yes___(explain)_____

Family History

		If Living		If Deceased	
		Age	Health	Age at Death	Cause
	Name:				
Birth Father	_____	____	_____	_____	_____
Birth Mother	_____	____	_____	_____	_____
Brothers/Sisters					
M__ F__	_____	____	_____	_____	_____
M__ F__	_____	____	_____	_____	_____
M__ F__	_____	____	_____	_____	_____
M__ F__	_____	____	_____	_____	_____
M__ F__	_____	____	_____	_____	_____

Do you know of any blood relatives (parents, siblings, aunts/uncles, grandparents) who have or have had the following (check and give relationship):

____Asthma_____
____Cough _____
____Hay Fever_____
____Allergies_____
____Obstructive Sleep Apnea_____
____Chronic Obstructive Pulmonary Disease_____
____GERD (Acid Reflux)_____
____Tuberculosis_____
____Cystic Fibrosis_____
____Sudden Infant Death Syndrome_____
____Aspirin Sensitivity_____
____Sudden Deaths_____

Social History

List who lives at home_____

Does anyone smoke at home? No___ Yes___
If yes, list who smokes and where: ___indoor ___outdoor ___car

Are there any pets at home? No___ Yes___
If yes, list all furry pets & where kept
___indoor _____
___outdoor_____

Is child in daycare? No ____ Yes___
If child is in school: School name _____ Grade _____
___Online ___Hybrid ___In class