

DuPage Medical Group

ASTHMA & ALLERGY CENTER

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Dr. Jacqueline Moran Dr. Brian Smart Dr. Thomas Van Osdol

Patient History (Pediatric)

Please take a few moments to complete the following **two page** patient questionnaire. Thank you.

Primary Care Provider: _____ **Referred by:** _____

What medical concerns would like addressed during today's visit (Chief Complaint)?

Please list **your child's** current and past **medical problems** and any prior **surgeries**:

Please list **your child's** current **medications** including dosages (if known). Please include any supplements, herbs, vitamins, etc.

Immunization history: Up to date Not up to date/delayed: _____

Medications allergies: _____

SOCIAL AND ENVIRONMENTAL HISTORIES:

Please help us get to know your child and his/her home environment a little better.

Personal History:

Home Environment:

Grade in School: _____	Live in: apt, house etc.. _____
School name: _____	Indoor animals: <input type="checkbox"/> Yes <input type="checkbox"/> No List: _____
Parents occupation(s): _____	Indoor smokers: <input type="checkbox"/> Yes <input type="checkbox"/> No List: _____
Daycare/preschool: _____	History of indoor water damage and/or indoor mold: <input type="checkbox"/> Yes <input type="checkbox"/> No
Other caretakers: _____	If yes, explain: _____
Tobacco/smoking history:	Does <i>your child</i> use "dust mite covers" for bedding: <input type="checkbox"/> Yes <input type="checkbox"/> No
1. Previous use: <input type="checkbox"/> Yes <input type="checkbox"/> No Quit date: _____	Heating and cooling (central or window AC, gas or electric heat, fireplace etc.): _____
2. Current use: <input type="checkbox"/> Yes <input type="checkbox"/> No If "yes," are you interested in quitting? <input type="checkbox"/> Yes <input type="checkbox"/> No	Flooring (carpet, laminate, tile, wood, etc.): _____
3. Packs per day/years: _____	
Hobbies/Interests: _____	

(PLEASE TURN PAGE OVER)

FAMILY MEDICAL HISTORY:

Do immediate family members have any of the conditions listed below (do not include your child)?

Condition:	Family history:	Who (i.e. mother, father, siblings, etc):
Allergies	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Sinus problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Other lung disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Eczema	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Thyroid problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Autoimmune disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Immune deficiency	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Migraines	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Other	Explain:	

REVIEW of SYSTEMS:Please check **Yes or No** to indicate if your child **currently** has any problems in one or more of the following areas. If yes, please circle and/or briefly explain the problem.

Organ system:	Yes or No	If yes, please circle all that apply:
General health:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Recurrent fever, chills, sweats, growth delay, speech problems, developmental delay, unexplained weight loss, weight gain, excessive fatigue, sleep problems
Eyes:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Blurred vision, eye pain, eye discharge, redness, watering, matting/crusting, itching, gritty sensation, eyelid rash/swelling
Ears/nose/throat:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hearing loss, earache, nasal congestion, nose bleeds, abnormal taste/smell, nasal drip, post nasal drip, allergies, dry mouth, sores in mouth, sore throat, hoarseness, throat clearing, bad breath
Cardiovascular:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Irregular heart beats, hypertension, heart problems,
Respiratory:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Asthma, bronchitis, cough, wheezing, shortness of breath, exercise difficulties
Gastrointestinal:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Reflux/heartburn, difficulty swallowing, nausea, vomiting, diarrhea, constipation, ulcers
Genitourinary:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Painful urination, frequent urination
Musculoskeletal:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Arthritis, joint pain, muscle pain, cramps, joint stiffness, joint swelling
Skin:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Dryness, rashes, itching, redness, swelling, change in moles
Neurology:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Headache, numbness/tingling, weakness, dizziness, lightheadedness
Psychiatry:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Anxiety, depression, ADD, ADHD
Endocrine:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Excessive thirst, cold intolerance, diabetes
Hematology:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Anemia, bleeding problems, enlarged lymph nodes

Physician Notes: _____

I have reviewed the information above.

Physician Signature

Date