EMORY HEALTHCARE
EMORY CHILDREN'S CENTER

Children's Healthcare of Atlanta

# New Patient Information
# Pediatric Pulmonary Clinic

*Dear Parent:*
*Please take some time to complete this form prior to your visit with the doctor. This information will allow us to provide better care for your child.*

Please describe briefly the main problem that brings you here today with your child, and why you think your doctor has referred you.

___________________________________________
___________________________________________
___________________________________________

Who is your child's primary care physician? ____________________ phone: ______________

Please list other specialists who have seen your child:

___________________________________________
___________________________________________

Please list all medications that your child takes.

| Medication | Dose | How often? | Every day or only as needed? |
|---|---|---|---|
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**Past Medical History**

What was your child's birth weight? __________

Was your child born prematurely? ☐ No ☐ Yes If yes, what was his/her gestational age? __________

Were there any problems in the newborn period? ☐ No ☐ Yes (please explain)

___________________________________________
___________________________________________

Has your child been hospitalized? ☐ No ☐ Yes (please give approximate dates and explain)

___________________________________________
___________________________________________

Is your child on any home medical equipment or oxygen? ☐ No ☐ Yes

If Yes, please list the type of equipment and the Home Care Company:

Equipment: ___________________________________________

___________________________________________

Home Care Company: ______________________________ phone: ______________

**Family History**

Mother's current age: _____ Does mother have any breathing problems, allergies, or any other significant medical problems? ☐ No ☐ Yes (please explain)

___________________________________________
___________________________________________

Father's current age: ______ Does father have any breathing problems, allergies, or any other significant medical problems? ☐ No ☐ Yes (please explain)

______________________________________________________________________________

______________________________________________________________________________

Please list all brothers and sisters with their ages and describe any breathing problems, allergies, or significant medical problems they might have:

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

If any other family members have any breathing problems or allergies, please describe:

______________________________________________________________________________

______________________________________________________________________________

Which members of the family live with the child? ________________________________________

Please list smokers in the family: ______________________________________________

Does the family live in a ☐ rental house ☐ owned house ☐ apartment ☐ other (explain) ____________

______________________________________________________________________________

Are there any pets? ☐ No ☐ Yes (please list): ________________________________________

**Review of Systems**

If the answer to any of the following is "Yes", please describe:

☐ No ☐ Yes Eye or Vision problems ______________________________________

☐ No ☐ Yes Ear problems/ ear infections ____________________________________

☐ No ☐ Yes Sinus/nasal problems ________________________________________

☐ No ☐ Yes Throat/tonsil problems _______________________________________

☐ No ☐ Yes Does the child snore during sleep? ______________________________

☐ No ☐ Yes Sleep apnea ______________________________________________

☐ No ☐ Yes Thyroid or other gland problems ________________________________

☐ No ☐ Yes Heart problems such as murmurs or chest pain _______________________

☐ No ☐ Yes Stomach/intestinal/diarrhea/constipation __________________________

☐ No ☐ Yes Stomach reflux/heartburn ______________________________________

☐ No ☐ Yes Genital or urinary problems ____________________________________

☐ No ☐ Yes Bone problems ____________________________________________

☐ No ☐ Yes Muscle problems __________________________________________

☐ No ☐ Yes Skin problems ____________________________________________

☐ No ☐ Yes Neurologic/seizure/developmental delay __________________________

☐ No ☐ Yes General symptoms (fever, lethargy, weight change, appetite change) ____________

______________________________________________________________________

Has your child had the following tests done?

☐ No ☐ Yes X-rays

☐ No ☐ Yes Sweat chloride

☐ No ☐ Yes Ph Probe

☐ No ☐ Yes Upper GI (gastro-intestinal)

☐ No ☐ Yes Bronchoscopy

☐ No ☐ Yes Lab tests (blood, urine)