

*Office Use Only*WT: \_\_\_\_\_\_kg \_\_\_\_\_\_ lb

HT: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Temp: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Resp: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pulse: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Oxygen: \_\_\_\_\_\_\_\_\_\_\_\_\_

BP: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Office Use Only*

VFC: [ ] V02 -- MDD

[ ] V03 -- No Ins

[ ] V04 -- Native

[ ] V07 -- AVAP

INSURANCE:

Copay / Co-ins

Statement Balance

**Asthma / Breathing Concerns**

**Is this a follow-up appointment? Yes / No.**

**Child’s name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Child’s birthday:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Who is your child’s primary care physician? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Since your child’s last visit:

* Does your child wheeze/cough (circle one)? Less than 2x/wk; More than 2x/wk; Everyday
* Number of nights your child woke up with asthma symptoms? \_\_\_\_\_\_\_\_
* Number of days your child’s asthma got in the way of physical/social activities? \_\_\_\_\_\_\_\_\_

|  |
| --- |
| ***For Girls Only if Applicable***  Last menstrual period was: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Periods started at age:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Any problems?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  *\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* |

* Number of days your child missed school because of asthma? \_\_\_\_\_\_\_\_
* Does your child use a rescue/reliever inhaler more than twice a week? \_\_\_\_\_\_\_\_\_
* Has your child been to the EMERGENCY ROOM? \_\_\_\_\_\_\_\_\_\_\_
* Has your child been HOSPITALIZED? \_\_\_\_\_\_\_\_\_\_\_

Does your child:

* Use a Peak Flow Meter Yes / No
* Have an Asthma Action Plan Yes / No
* Use a mask or spacer with an inhaler Yes / No
* Have an inhaler at school Yes / No
* Use a nebulizer machine Yes / No

**Other symptoms:**

Fever Yes / No. If yes, how long? \_\_\_\_\_\_\_\_\_ Abdominal pain Yes / No. If yes, how long? \_\_\_\_\_\_\_\_\_

Nasal discharge Yes / No. If yes, how long? \_\_\_\_\_\_\_\_\_ Decreased appetite Yes / No. If yes, how long? \_\_\_\_\_\_\_\_\_

Earache Yes / No. If yes, how long? \_\_\_\_\_\_\_\_\_ Nausea/Vomiting Yes / No. If yes, how long? \_\_\_\_\_\_\_\_\_

Sore throat Yes / No. If yes, how long? \_\_\_\_\_\_\_\_\_ Diarrhea Yes / No. If yes, how long? \_\_\_\_\_\_\_\_\_

Headache Yes / No. If yes, how long? \_\_\_\_\_\_\_\_\_ Rash Yes / No. If yes, how long? \_\_\_\_\_\_\_\_\_

Does your child have a medication allergy? Yes / No. What medication/reaction? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does your child have any chronic medical problems? Yes / No. If yes, please explain. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has your child been admitted to the hospital overnight? Yes / No. If yes, please explain. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has your child had any surgeries? Yes / No. If yes, please explain. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is your child taking any daily prescribed medications? Yes/no. If yes, please explain. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is your child taking any over-the-counter cold medications? Yes/No. If yes, please list: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Motrin or Tylenol? Yes/No

Has your child been around anyone who is sick? Yes / No. Who? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does anyone in the family have:

Asthma Yes / No please circle: father / mother / brother / sister

Seasonal allergies Yes / No please circle: father / mother / brother / sister

Does anyone in the family smoke (includes outside of the house)? Yes / No. If yes, who? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Any pets? Yes / No. Which kind/how many? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does your child attend daycare/preschool/school? (please circle) What grade in school or daycare? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does your child participate in any sports? Yes / No. If yes, which sport(s)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are your child’s immunizations up-to-date? Yes/no. If no, please explain. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**This form completed by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Child: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Today’s Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**