

# Amarillo Children's Pulmonology Clinic

Patient Name: \_\_\_\_\_

Paul K. Nolan, MD, FAAP

Date of

Birth: \_\_\_\_\_

Pediatric Pulmonologist, BC

#17 Care Circle

Amarillo, TX 79124

(806) 468-6277

☺Welcome to the Amarillo Children's Pulmonology Clinic! Please take a few minutes to fill out this questionnaire about the individual with breathing problems.☺

Date \_\_\_\_\_ Name of person completing survey \_\_\_\_\_

- How old was your child when he/she first started having breathing problems? \_\_\_\_\_
- Which of the following breathing problems are present at any time? (check all that apply)  
 shortness of breath       cough  
 chest tightness       wheezing (high-pitched noise when breathing out)
- Do the breathing problems occur with any of the following things? (check all that apply)  
 animals       tobacco smoke       dust  
 perfumes, cleaning agents       cold weather       automobile exhaust  
 colds       laughing hard       crying hard  
 running hard       Other: \_\_\_\_\_
- In the past **2 weeks**, how many times have breathing problems occurred:
  - During the day (other than because of physical activity)?  
 None     ≤ 1 attack per week     >1 attack per week but < 1 attack a day  
 Daily     Continuous (at rest)
  - At night causing awakening (check most appropriate)?  
 None     ≤ 1 attack per week     >1 attack per week but < 1 attack a day  
 Nightly
  - After running, exercise, or other physical activity?  
 Never       Sometimes       Always
- Are the breathing problems worse at any of the following times of year?  
 Spring     Summer     Fall     Winter
- Are there any symptoms of constant or seasonal stuffy nose, runny nose and/or postnasal drip?  
 Never     Sometimes     Always  
If so, what season(s):  Spring     Summer     Fall     Winter
- How many times has he/she been hospitalized for breathing problems since birth? \_\_\_\_\_  
Past year? \_\_\_\_\_ When? \_\_\_\_\_
- How many times has he/she been to the ER for respiratory problems since birth? \_\_\_\_\_  
Past year? \_\_\_\_\_ When? \_\_\_\_\_

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9. Has he/she been in the Pediatric Intensive Care Unit for breathing problems? Yes No  
If so how many times? \_\_\_\_\_
10. Has he/she ever been intubated because of breathing problems? Yes No
11. Was he/she born premature? Yes No  
If so how early? \_\_\_\_\_ If on ventilator, how long? \_\_\_\_\_ How long on oxygen? \_\_\_\_\_
12. How many times has he/she received oral steroids (Orapred, PediaPred, Prelone, Prednisolone, Prednisone) for breathing problems in the past year? \_\_\_\_\_
13. How many times a week does he/she use a "rescue" medication for breathing problems (Albuterol, Pro-Air, Maxair, Proventil, Ventolin, Xopenex)? \_\_\_\_\_
14. How many days of school or work have been missed due to breathing problems in the past year? \_\_\_\_\_  
In the past month? \_\_\_\_\_
15. Are you using a spacer? Yes No Is your spacer an Aerochamber? Yes No Don't know
16. Are any pets kept indoors? Yes No What kind? \_\_\_\_\_
17. Any visible mold in the home? Yes No
18. Any cockroaches seen in the home in the past month? Yes No
19. Does anyone who lives with or care for your child smoke **including smoking outside or at work**, and come back in or back home? Yes No Who smokes? \_\_\_\_\_
20. Is there a wood-burning stove in the home? Yes No
21. Is there exposure to stuffed toys? Yes No
22. Is the house carpeted? Yes No
23. What type of pillow is slept on? \_\_\_Synthetic \_\_\_Down or feather \_\_\_None
24. Are pillows and mattress encased in plastic covers? Yes No
25. Do any of the parents or siblings suffer from?  
Yes\_\_\_ No\_\_\_ recurrent coughing, wheezing or shortness of breath, who? \_\_\_\_\_  
Yes\_\_\_ No\_\_\_ seasonal, itchy, runny nose, who? \_\_\_\_\_  
Yes\_\_\_ No\_\_\_ eczema (dry, scaly, red skin especially to elbows, knees and face), who? \_\_\_\_\_
26. Do any of the relatives suffer from?  
Yes\_\_\_ No\_\_\_ cystic fibrosis (inherited disease of the lungs and pancreas), who? \_\_\_\_\_  
Yes\_\_\_ No\_\_\_ sickle cell anemia, who? \_\_\_\_\_  
Yes\_\_\_ No\_\_\_ recurrent lung infections, \_\_\_\_\_  
Yes\_\_\_ No\_\_\_ Emphysema/COPD, who? \_\_\_\_\_  
Yes\_\_\_ No\_\_\_ Tuberculosis (TB) who? \_\_\_\_\_

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Yes \_\_\_ No \_\_\_ premature death before 40 years old, who? \_\_\_\_\_

27. Are his/her immunizations up to date? \_\_\_ Yes \_\_\_ No

28. Has your child received the influenza vaccine for this year? \_\_\_ Yes \_\_\_ No \_\_\_ Don't know

29. Has your child received the 23 valent pneumonia vaccine (Pneumovax) in the last 5 years?  
\_\_\_ Yes \_\_\_ No \_\_\_ Don't know

30. What Pharmacy do you use: \_\_\_\_\_ Location \_\_\_\_\_

31. Current Medications

Medication	Dose, Number of times per day

Do you have any questions or concerns about you breathing problems that you would like for us to address at this visit?

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