Lewis J. Kass, MD

Westchester Pediatric Pulmonology & Sleep Medicine

103 So. Bedford Road / Mt. Kisco, NY 10549

914.242.0445

Name _____ Date _____

Reason for Visit: _____

_____

_____

This has been a problem since: _____

_____

Does exposure to any of the following make your child's symptoms appear or get worse?

- ☐ Weather changes
- ☐ Temperature changes (hot to cold; cold to hot)
- ☐ Rainy days
- ☐ Foggy days
- ☐ House cleaning
- ☐ Recently mowed lawn
- ☐ Excitement/anger
- ☐ Physical exertion
- ☐ Being around animals
- ☐ Insecticides
- ☐ Chemicals
- ☐ Fumes
- ☐ Aerosols
- ☐ Perfumes
- ☐ Cosmetics
- ☐ Cigarette smoke
- ☐ Infection (virus), colds, flu
- ☐ Playing in the grass
- ☐ Specific foods

If not already part of the chief complaint, does your child have any of the following symptoms:

- ☐ cough during sleep
- ☐ cough from exercise
- ☐ wheeze
- ☐ wheeze from exercise
- ☐ recent cold or chest illness
- ☐ exercise intolerance
- ☐ recent change in weight
- ☐ snoring
- ☐ mouth breathing
- ☐ disturbed or restless sleep
- ☐ witnessed apneas snorts or arousals
- ☐ hyperactivity
- ☐ irritability
- ☐ poor school performance

Birth History

Birth weight _____

Full term? No _____ Yes ____ If premature, how premature?_____

Pregnancy Normal _____ Abnormal (explain)_____

_____

_____

Delivery Normal _____ Abnormal (explain)_____

_____

Problems during the newborn period? No ____ Yes ____

If yes, explain _____

_____

_____

Are your child's **immunizations** (baby shots) up to date? Yes ____ No ____

Has your child ever been **hospitalized**? No ____ Yes ____

Reason	Date	Hospital

Name _____ Date _____

Has your child ever seen a specialist for other problems? No ____ Yes ____
Name and specialty _____

Has your child had allergy testing? No ____ Yes ____ When _____
By whom _____
Findings _____
Has your child had chest x-rays? No ____ Yes ____ When _____
Findings _____

Please list any medications your child has taken:

Name of Medication	Still taking this medication (Y or N)

Family History

Check ✓ if any family members (grandparents, cousins, aunts, uncles, brothers, sisters) have had any of the following:

	Condition	Who		Condition	Who
☐	Allergy		☐	Asthma	
☐	Hay Fever		☐	Recurrent pneumonias	
☐	Snoring		☐	Sinusitis	
☐	Obstructive sleep apnea		☐	Obesity	
☐	SIDS		☐	Bronchitis or emphysema	
☐	Cystic Fibrosis		☐	Tuberculosis	
☐	Heart Disease		☐	Diabetes	
☐	Cancer		☐	Insomnia	
☐	Night terrors				

Father Age _____ Occupation _____
Smoker? _____ How much? _____
Health Problems? _____

Mother Age _____ Occupation _____
Smoker? _____ How much? _____
Health Problems? _____

Are there any other children in the patient's family? No ____ Yes ____

Name	Age	Birth Date	Health Problems

Name _____ Date _____

Environmental History

How long have you lived in your present home? _____

Type of home: Private House_____ Apartment_____

Type of heat: Radiators_____ Forced Hot Air_____

Location: Wooded_____ City_____ Near highway or factory_____

Pets: Cats_____ Dogs_____ Other_____

How long have you had the pet? _____

Do you use or have any of the following in your child's bedroom or in your home?

- ☐ wall to wall carpetting
- ☐ stuffed animals
- ☐ mattress covers
- ☐ air purifier (HEPA)
- ☐ humidifier
- ☐ pillow covers

Are there any issues at home with any of the following?

- ☐ roaches
- ☐ rats or mice
- ☐ mold
- ☐ water damage

Sleep

Do you have concerns about your child's sleep patterns or behavior?

_____

_____

_____

_____

_____

_____

Nutrition:

- ☐ formula_____
- ☐ milk_____
- ☐ dietary concerns?_____

Bowel Movements: Normal ____ Abnormal ____

DRUG OR FOOD ALLERGIES_____