Banner Health®

NEW PATIENT MEDICAL HISTORY - PEDIATRIC PULMONOLOGY

Patient Name: _____ **Date of Birth:** _____ **Gender: M / F**

Person filling out form and relationship to patient: _____

Please provide as much detail as you are able so that we can give you the safest and best care possible.

Preferred Pharmacy (name and location): _____

Primary Care Provider

Name: _____ Phone #: _____

Address: _____ Fax #: _____

Reason for visit: _____

ALLERGIES

❑ **No known allergies** List any allergies and intolerances to **medications, food or the environment.**

Allergy:	**Reaction:**

MEDICATIONS

❑ **No Medications** List any medications you are taking, with dose and how often.

Medication Name:	**Dose:**	**How often?**

IMMUNIZATIONS

❑ Immunization History Unknown ❑ Immunization up-to-date ❑ No immunizations by choice ❑ Missing some immunizations

Date of last influenza vaccine: _____

PATIENT MEDICAL HISTORY

List any current or past medical conditions (please place checkmark by any current problems).

❑ _____

❑ _____

❑ _____

❑ _____

❑ _____

DO NOT RETAIN AS PART OF THE PERMANENT MEDICAL RECORD

9999-0130
(01/2017)

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SURGERIES AND/OR HOSPITALIZATIONS

Has your child had any surgeries or has been hospitalized? (provide dates and reason below)?

Date:	Reason:	Date:	Reason:

FAMILY HISTORY

List health conditions for each family member.

	Alive	Deceased	Age of Death	Health Condition(s)
Father				
Mother				
Paternal Grandmother				
Paternal Grandfather				
Maternal Grandmother				
Maternal Grandfather				
Brother				
Sister				

SOCIAL HISTORY

Patient lives with: ❑ Mother ❑ Father ❑ Siblings ❑ Grandparents ❑ Step-Parents ❑ Foster Parents ❑ Adoptive Parents

Child attends school/daycare: _____ Grade: _____ Not applicable _____

Extracurricular activities/sports: _____

Does anyone in the home smoke? ❑ Yes ❑ No If yes, do they smoke outside only? ❑ Yes ❑ No

If yes, do they smoke in the car? ❑ Yes ❑ No

Are there pets in the home? ❑ Yes ❑ No If yes, list: _____

TOBACCO / ALCOHOL / CAFFEINE / DRUGS

(For patients 12 and older)

Tobacco/smoking status: Never _____

Current _____ Type _____ Amount _____ Duration _____

Former _____ Type _____ Amount _____ Duration _____

Do you use alcohol? No _____ Yes _____ Type _____ Amount _____ Frequency _____

Do you use Caffeine? No _____ Yes _____ Type _____ Amount _____ Frequency _____

BIRTH HISTORY

(Complete if under 4 years old)

Birth Weight: _____ lbs. _____ oz. Type of delivery: ❑ Vaginal ❑ C-Section

Gestational age at birth: _____ weeks Place of birth (state): _____

Any complications during pregnancy? ❑ Yes ❑ No If yes, explain: _____

Any complications at birth? ❑ Yes ❑ No If yes, explain: _____

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REVIEW OF SYSTEMS

Please mark all that currently apply.

GENERAL			CARDIOVASCULAR			HEMATOLOGIC IMMUNOLOGIC		
Change in appetite	Yes	No	Cyanosis (blue spells)	Yes	No	Abnormal bleeding	Yes	No
Exercise intolerance	Yes	No	Heart murmur	Yes	No	Easy bruising	Yes	No
Fever	Yes	No	Irregular heart beat	Yes	No	Infections (reoccurring)	Yes	No
Weight loss	Yes	No	Pressure in the chest	Yes	No	**MUSCULOSKELETAL**		
ENT			Swollen ankles	Yes	No	Growing pains	Yes	No
Difficulty hearing	Yes	No	**GASTROINTESTINAL**			Joint pain/bone pain	Yes	No
Difficulty swallowing	Yes	No	Abdominal pain	Yes	No	Poor coordination	Yes	No
Dry mouth	Yes	No	Acid reflux/heartburn	Yes	No	**NEUROLOGICAL**		
Ear pain	Yes	No	Blood in stool	Yes	No	Dizzy/light headed	Yes	No
Mouth sores	Yes	No	Constipation	Yes	No	Fainting	Yes	No
Nasal congestion/stuffy nose	Yes	No	Diarrhea	Yes	No	Headaches	Yes	No
Nasal speech	Yes	No	Nausea	Yes	No	Heat/cold intolerance	Yes	No
Sinus problems	Yes	No	Vomiting	Yes	No	Numbness in arms/legs	Yes	No
Sore throat	Yes	No	**GENITOURINARY**			Staring spells	Yes	No
RESPIRATORY			Bed wetting	Yes	No	Tics	Yes	No
Apnea	Yes	No	Blood in urine	Yes	No	**PSYCHOLOGICAL**		
Cough	Yes	No	Trouble urinating	Yes	No	Aggressive/anger	Yes	No
Coughing up blood	Yes	No	Urinary tract infection	Yes	No	Anxiety	Yes	No
Nighttime cough	Yes	No	**SKIN**			Cries easily	Yes	No
Noisy breathing	Yes	No	Rash	Yes	No	Difficulty completing tasks	Yes	No
Shortness of breath	Yes	No				Easily distracted	Yes	No
Wheezing	Yes	No				Easily frustrated	Yes	No
						Trouble sleeping	Yes	No

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