NorthEast Pediatric Pulmonology

Alan Harsch, MD

New Patient Information

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.

Patient Name: ______________________ **DOB:** ______________

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?	Everyday or Only as Needed?

DRUG ALLERGIES: Please list any drug allergies you child has:

PAST MEDICAL HISTORY:

What was your child's birth weight? ______________ Was your child born prematurely? ☐ Yes ☐ No

If "yes", what was the gestational age? __________ Where there any problems in the newborn period? ☐ Yes ☐ No

Please explain:

Has your child ever been hospitalized? (If yes, please give approximate dates and explain)

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

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 other medical problems? ☐ Yes ☐ No

Please explain:

Father's current age: ________ Does father have any breathing problems, allergies or other medical problems? ☐ Yes ☐ No

Please explain:

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

NAME	AGE	PROBLEM

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) ________

NorthEast Pediatric Pulmonology

Alan Harsch, MD

REVIEW OF SYSTEMS:

Please select "Yes" or "No", if the answer to any of the following is "Yes", please describe:

Eye or Vision Problems	☐ Yes ☐ No	______
Ear Problems/Ear Infections	☐ Yes ☐ No	______
Sinus/Nasal Problems	☐ Yes ☐ No	______
Throat/Tonsil Problems	☐ Yes ☐ No	______
Does the Child Snore During Sleep?	☐ Yes ☐ No	______
Sleep Apnea?	☐ Yes ☐ No	______
Thyroid or Other Gland Problems	☐ Yes ☐ No	______
Heart Problems such as murmurs or chest pain	☐ Yes ☐ No	______
Stomach/Intestinal/Diarrhea/Constipation	☐ Yes ☐ No	______
Stomach Reflux/Heartburn	☐ Yes ☐ No	______
Genital or Urinary Problems	☐ Yes ☐ No	______
Bone Problems	☐ Yes ☐ No	______
Muscle Problems	☐ Yes ☐ No	______
Skin Problems	☐ Yes ☐ No	______
Neuralgic/Seizure/Development Delay	☐ Yes ☐ No	______
General Symptoms (fever, lethargy, weight change, appetite change)	☐ Yes ☐ No	______

Has your child had the following test done?

X-Rays	☐ Yes ☐ No	**Upper GI (Gastro-Intestinal)**	☐ Yes ☐ No
Sweat Chloride	☐ Yes ☐ No	**Bronchoscopy**	☐ Yes ☐ No
Ph Probe	☐ Yes ☐ No	**Lab Tests (Blood, Urine)**	☐ Yes ☐ No

______
Responsible Party **Date**

______
Physician **Date**

______
Physician Signature **Date**

______
RN Signature **Date**