Weill Cornell Medical College

NewYork-Presbyterian
Phyllis and David Komansky
Center for Children's Health

PULMONARY QUESTOINNAIRE

Patient: Date of Birth:

Address: Phone:

Pediatrician: Phone:

Address: Fax:

1. What problem brought you and your child to the doctor today?

2. How long has he/she had these symptoms?

3. Place an "X" if your child has had any of the following:

- ☐ Persistent Cough
- ☐ Barking Cough
- ☐ Cough when Drinking/Eating
- ☐ Noisy Breathing
- ☐ Wheezing
- ☐ Wheezing with Exercise
- ☐ Rattling Noise in the Throat
- ☐ Rattling Noise in the Chest
- ☐ Hoarseness
- ☐ Bronchitis
- ☐ Bronchiolitis
- ☐ Pneumonia
- ☐ Difficulty Breathing
- ☐ Snoring
- ☐ Weight Loss
- ☐ Poor Weight Gain
- ☐ Poor Growth
- ☐ Poor Development (Slow)
- ☐ Frequent Headaches
- ☐ Frequent Sinus Infections (More than 3)
- ☐ Frequent Ear Infections (More than 3)
- ☐ Nose Runs Often
- ☐ Nose Itches Often (Rubs Nose)
- ☐ Eyes Itch Often
- ☐ Eyes Get Red
- ☐ Eyes Get Teary

- [ ] Apnea (Stop Breathing)
- [ ] Foul Breath
- [ ] Distended Abdomen
- [ ] Excessive Gas
- [ ] Frequent Abdominal Pain (Belly Aches)
- [ ] Frequent Vomiting
- [ ] Vomits when Drinking
- [ ] Food Allergy
- [ ] Eyes Get Swollen
- [ ] Blue Circle Under the Eye
- [ ] Eczema
- [ ] Skin Rashes
- [ ] Other:

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

- [ ] Weather Changes
- [ ] Temperature Changes (Hot to Cold or Cold to Hot)
- [ ] Rainy Days
- [ ] Foggy Days
- [ ] House Cleaning
- [ ] Recently Mowed Lawn
- [ ] Excitement/Anger
- [ ] Physicial Exertion
- [ ] Being Around Animals
- [ ] Insecticides
- [ ] Chemicals
- [ ] Fumes
- [ ] Aerosols
- [ ] Perfumes
- [ ] Cosmetics
- [ ] Cigarette Smoke
- [ ] Infection (Virus), Colds, Flu
- [ ] Specific Foods

5. Bowel Movements: ☐ Normal ☐ Abnormal (If abnormal, please place an "X" below)

- [ ] Very Foul Smelling
- [ ] Very Pale
- [ ] Very Hard
- [ ] Other:
- [ ] Large
- [ ] Loose or Diarrhea
- [ ] Very Infrequent (Constipated)
- [ ] Float
- [ ] Greasy

6. Are your child's immunizations (baby shots) up to date? ☐ Yes ☐ No

7. Basic History:

A. Birth Weight: Present Weight:
B. Pregnancy: ☐ Normal Abnormal (explain):
C. Delivery: ☐ Normal Abnormal (explain):
D. Full Term? ☐ Yes ☐ No If premature, how premature?
E. Problems during the newborn period? ☐ Yes ☐ No
If yes, explain:

8. Has your child ever been hospitalized? ☐ Yes ☐ No If yes:

Reason	**Date**	**Hospital**

9. Has your child ever seen a specialist for other problems? ☐ Yes ☐ No
If yes, name:

10. Has your child had allergy testing? ☐ Yes ☐ No When?
    By whom?

11. Has your child had chest x-rays? ☐ Yes ☐ No When?
    By whom?

12. Has your child taken any medication? ☐ Yes ☐ No (Complete Below)

Name of Medication	**Reason**

13. Place an "X" if any family members (grandparents, cousins, aunts, uncles, brothers, sisters) have had any of the following:

Condition	**Relationship**	**Condition**	**Relationship**
☐ Allergy		☐ Asthma	
☐ Hay Fever		☐ Diabetes (sugar)	
☐ Cystic Fibrosis		☐ Tuberculosis	
☐ Cancer		☐ Heart Disease	
☐ Anemia		☐ Bronchitis/Emphysema	
☐ Liver Disease		☐ Hemophilia/Bleeding	
☐ Digestive Disorder		☐ SIDS	
☐ Eczema		☐ Sickle Cell Disease	

14. Father: Age Occupation:
    Smoker? ☐ Yes ☐ No How much?

15. Mother: Age Occupation:
    Smoker? ☐ Yes ☐ No How much?

16. Are there any other children in the patient's family? ☐ Yes ☐ No

Name	Age	Date of Birth	Health Problems

A. How long have you lived in your present home?

B. Type of home (e.g. apartment, house):

C. Type of Heat: ☐ Gas ☐ Oil ☐ Air Conditioner

D. Pets: ☐ Indoor Cats: ☐ Yes ☐ No Dogs: ☐ Yes ☐ No

E. How long have you had it?

F. Pillow Type: With or Without Plastic Cover:

G. Mattress Type: With or Without Mattress Cover:

H. Blanket Type: How old is it?

I. Rug Type: J. Draperies:

K. Indoor Plants: L. Stuffed Toys in Bedroom:

M. Floor: ☐ Carpet ☐ Wood ☐ Linoleum N. Humidifier in room? ☐ Yes ☐ No

O. Air purifier in home? ☐ Yes ☐ No P. Do you see rats/mice? ☐ Yes ☐ No

Q. Do you see cockroaches? ☐ Yes ☐ No R. TV/DVD in child's room? ☐ Yes ☐ No

Patient's/Representative's Name Patient's/Representative's Signature Date

Relationship to Patient:

Physician's Signature Date

December 2011