RESPIRATORY Follow-up Form
Please answer each question

Patient Label

1. Since your last visit with us, have ***RESPIRATORY PROBLEMS*** resulted in any of the following events:

	YES	NO	NUMBER
urgent care visits	☐	☐	_____
unscheduled MD visits	☐	☐	_____
oral steroid bursts	☐	☐	_____
daycare/school day loss	☐	☐	_____
parent work day loss	☐	☐	_____
family activity loss	☐	☐	_____
parent activity loss	☐	☐	_____

2. Normal cough occurs 5 to 15 times per day, is not dramatic, and does not interfere with play, sleep, or eating. ***When well***, does your child have ***abnormal cough*** as follows:

	YES	NO	Rare/Often
cough with activity	☐	☐	_____
cough at night	☐	☐	_____
cough during the day	☐	☐	_____

3. ***When well***, does your child have ***activity limited*** by the following:

	YES	NO	Rare/Often
cough	☐	☐	_____
wheeze	☐	☐	_____
shortness of breath	☐	☐	_____

4. ***When well***, does your child have ***nighttime awakenings*** from any of the following:

	YES	NO	Rare/Often
cough	☐	☐	_____
wheeze	☐	☐	_____
shortness of breath	☐	☐	_____

5. ***When well***, does your child require rescue meds like ALBUTEROL, VENTOLIN, XOPENEX, OR MAXAIR:

	YES	NO	Rare/Often
during the day	☐	☐	_____
during the night	☐	☐	_____

6. ***Since your last visit***, has your child experienced any of the following problems:

	YES	NO	Rare/Often
sinusitis	☐	☐	_____
ear infections	☐	☐	_____
allergic drainage	☐	☐	_____
asthma events	☐	☐	_____
eczema flare	☐	☐	_____
mucus with cough	☐	☐	_____

7. Is your child ***presently*** exposed to any of the following situations:

	YES	NO	Rare/Often
wood burning	☐	☐	_____
home water damage/mold	☐	☐	_____
pets in the home	☐	☐	_____
insects in the home	☐	☐	_____
rodents in the home	☐	☐	_____
daycare / school	☐	☐	_____

8. Is your child ***presently*** exposed to cigarette, cigar, or pipe smoke?

	YES	NO	Rare/Often
any smoking in the home	☐	☐	_____
a parent out of the home	☐	☐	_____
smoking by your child	☐	☐	_____
smoking by a relative	☐	☐	_____

other: _____

9. Are you experiencing any of the following ***barriers*** to respiratory health:

	YES	NO
my child ***resists*** taking medications	☐	☐
I ***forget*** to give the medications	☐	☐
nebulizations are especially difficult	☐	☐
steroid use frightens me	☐	☐
antibiotic use worries me	☐	☐
medication **COSTS** are a problem	☐	☐

CONTINUE QUESTIONS ON THE FLIP SIDE

10. Review of Systems

Circle any symptoms that your child is now experiencing:

Well Being	Vision/Hearing	Skin	Cardiac	Genitourinary
weight loss	blurry vision	eczema	sweating with activity	increased urine output
fever or chills	eye discomfort	rashes	racing heart	decreased urine output
easy fatigue	eye drainage	hives	chest pain	pain on urination
activity disinterest	hearing change	skin color change	puffy eyes or face	menstrual change
	vision change	pale skin color	passing out	
			skipped beats	

Neurologic	Musculoskeletal	Bleeding Issues	Hormonal	Gastrointestinal
headache	muscle pain	easy bruising	hair loss	vomiting
dizziness	joint swelling	nose bleeds	excess hair growth	diarrhea
new clumsiness	joint stiffness	blood in urine	cold intolerance	stomach/belly pain
difficulty walking	new weakness	blood in stool	heat intolerance	stomach/belly cramps
			weight loss but eating	nausea

☐ None of the above

11. Do you have any other concerns regarding your child's health?