

CRCCS Pre-Visit Questionnaire

Please answer each question

Name: _____

DOB: _____

1. What you would like to discuss at your child's visit?

2. Since your last visit with us, have *respiratory problems* resulted in any of the following events:

	<u>YES</u>	<u>NO</u>	<u>NUMBER</u>
urgent care visits (Not ER/ED)	<input type="checkbox"/>	<input type="checkbox"/>	_____
daycare/school day loss	<input type="checkbox"/>	<input type="checkbox"/>	_____
ICU admissions	<input type="checkbox"/>	<input type="checkbox"/>	_____
Oral steroid "bursts"	<input type="checkbox"/>	<input type="checkbox"/>	_____

3. *When well*, does your child have cough, wheezing or shortness of breath:

	<u>YES</u>	<u>NO</u>	<u>Rare/Often</u>
during the day	<input type="checkbox"/>	<input type="checkbox"/>	_____
with activity	<input type="checkbox"/>	<input type="checkbox"/>	_____
with sleep	<input type="checkbox"/>	<input type="checkbox"/>	_____

4. *When well*, does your child require rescue meds like ALBUTEROL or XOPENEX for symptom treatment:

	<u>YES</u>	<u>NO</u>	<u>Rare/Often</u>
during the day	<input type="checkbox"/>	<input type="checkbox"/>	_____
during the night	<input type="checkbox"/>	<input type="checkbox"/>	_____

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

	<u>YES</u>	<u>NO</u>	<u>Rare/Often</u>
Sinusitis (sinus infection)	<input type="checkbox"/>	<input type="checkbox"/>	_____
ear infections	<input type="checkbox"/>	<input type="checkbox"/>	_____
allergic drainage	<input type="checkbox"/>	<input type="checkbox"/>	_____
snoring	<input type="checkbox"/>	<input type="checkbox"/>	_____
eczema flare	<input type="checkbox"/>	<input type="checkbox"/>	_____
mucus with cough	<input type="checkbox"/>	<input type="checkbox"/>	_____

6. Is your child *presently* exposed to the following:

	<u>YES</u>	<u>NO</u>	<u>Rare/Often</u>
wood burning	<input type="checkbox"/>	<input type="checkbox"/>	_____
home water damage/mold	<input type="checkbox"/>	<input type="checkbox"/>	_____
pets in the home	<input type="checkbox"/>	<input type="checkbox"/>	_____
roaches in the home	<input type="checkbox"/>	<input type="checkbox"/>	_____
daycare / school	<input type="checkbox"/>	<input type="checkbox"/>	_____

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

	<u>YES</u>	<u>NO</u>
my child resists taking medications	<input type="checkbox"/>	<input type="checkbox"/>
forget to give/take medications	<input type="checkbox"/>	<input type="checkbox"/>
steroid use frightens me	<input type="checkbox"/>	<input type="checkbox"/>

8. Do you prefer alternative medical treatments to standard medications?

YES NO

9. **Review of Systems:** Circle any symptoms your child is *currently* experiencing:

<u>Overall</u>	<u>Cardiac:</u>	<u>Neurologic:</u>
<u>Wellbeing:</u>	<input type="checkbox"/> Excessive sweating	<input type="checkbox"/> Headache
<input type="checkbox"/> Weight Loss	<input type="checkbox"/> Racing heart	<input type="checkbox"/> Dizziness
<input type="checkbox"/> Fever or Chills	<input type="checkbox"/> Chest pain	<input type="checkbox"/> Clumsiness
<input type="checkbox"/> Easy Fatigue	<input type="checkbox"/> Fainting	<input type="checkbox"/> Difficulty walking
<input type="checkbox"/> Activity Disinterest	<input type="checkbox"/> Skipped beats	<u>Musculoskeletal:</u>
<u>Vision/Hearing:</u>	<u>Gastrointestinal:</u>	<input type="checkbox"/> Muscle pain
<input type="checkbox"/> Blurry vision	<input type="checkbox"/> Increased urine	<input type="checkbox"/> Joint swelling
<input type="checkbox"/> Eye discomfort	<input type="checkbox"/> Decreased urine	<input type="checkbox"/> Joint stiffness
<input type="checkbox"/> Eye drainage	<input type="checkbox"/> Pain on urination	<input type="checkbox"/> Weakness
<input type="checkbox"/> Hearing change	<input type="checkbox"/> Menstrual change	<u>Bleeding Issues:</u>
<input type="checkbox"/> Vision change	<u>Gastrointestinal:</u>	<input type="checkbox"/> Easy bruising
<u>Skin:</u>	<input type="checkbox"/> Vomiting	<input type="checkbox"/> Nose bleeds
<input type="checkbox"/> Eczema	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Blood in urine
<input type="checkbox"/> Rashes	<input type="checkbox"/> Stomach pain	<input type="checkbox"/> Blood in stool
<input type="checkbox"/> Hives	<input type="checkbox"/> Nausea	<u>Hormonal:</u>
<input type="checkbox"/> Skin color change	<input type="checkbox"/> Heartburn	<input type="checkbox"/> Hair loss
		<input type="checkbox"/> Excess hair growth
		<input type="checkbox"/> Cold intolerance
		<input type="checkbox"/> Heat intolerance

None of the above

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*NOTE: By submitting this document to Children's Respiratory & Critical Care Specialists, you are providing implied consent that you understand the risks of sending personal health information in a non-secure email format.