Rocky Mountain Pediatric Respiratory and Allergy Care
Patient Registration

Patient's Name (Last) _____ (First) _____ (M.I.) _____
DOB: _____ Age: _____ Male □ Female □ SS# (if known): _____
Address:_____
Language:_____ Ethnicity: □ Hispanic or Latin □ Not Hispanic or Latin
Race: □ American Indian/Alaska Native □ Asian □ Native Hawaiian/Other Pacific Islander □ Black/African American □ White
Child lives with □ Both parents □ Father □ Mother □ Other (specify):_____

Parent #1's Information:
Mother's Name (Last) _____ (First) _____ (M.I.)_____
DOB: _____ Email Address:_____ Permission to contact via Email: Yes □ No □
Address: Same as above □
_____ Permission to leave detailed information on a voicemail (including lab results, etc.)
Phone: _____ Mobile: _____ □ Phone □ Mobile □ Neither

Parent #2's Information:
Father's Name (Last) _____ (First) _____ (M.I.)_____
DOB: _____ Email Address:_____ Permission to contact via Email: Yes □ No □
Address: Same as above □
_____ Permission to leave detailed information on a voicemail (including lab results, etc.)
Phone: _____ Mobile: _____ □ Phone □ Mobile □ Neither

Primary Care/Pediatrician's Information:
Physician's Name: _____ Practice Name: _____
Address (if known): _____
(Street) (City) (State) (Zip)
Phone (if known): _____

Referring Physician's Information: Same as above □
Physician's Name: _____ Practice Name: _____
Address (if known): _____
(Street) (City) (State) (Zip)
Phone (if known): _____

Local Pharmacy	Mail Order/Alternate Pharmacy
Name: _____	Name: _____
Address: _____	Address: _____
Phone: _____	Phone: _____
Fax: _____	Fax: _____

Primary Insurance Information:
Insurance Name: _____ ID #: _____ See Card □
Insurance Policy Holder Name: _____ Policy Holder DOB: _____
Insured's Employer: _____

Secondary Insurance Information:
Insurance Name: _____ ID #: _____ See Card □
Insurance Policy Holder Name: _____ Policy Holder DOB: _____
Insured's Employer: _____

I agree that the information supplied on this form is accurate and up to date to the best of my knowledge.

Patient (or Responsible Party) Signature: _____ Date: _____

PAST MEDICAL HISTORY

Length of pregnancy: ☐ Full-term ☐ Early (# of weeks) ____ ☐ Late (# of weeks) _____

Birth weight ___ lbs. _____ oz Type of delivery ☐ Vaginal, normal ☐ Vaginal, breech
☐ Planned C-section ☐ Emergency C-section

Were there problems with the pregnancy? If yes, specify _____

Were there problems with labor or delivery? If yes, specify _____

Did your child have breathing problems at birth?

☐ No ☐ Yes (specify) _____

Was your child breast fed? ☐ No ☐ Yes (specify # of months) _____

Was your child formula fed? ☐ No ☐ Yes (specify formula type) _____

☐ Cow's milk ☐ Soy milk ☐ Other (specify) _____

Did your child have colic? ☐ No ☐ Yes

What was your child's growth pattern? ☐ Normal ☐ Rapid ☐ Slow

What was your child's development rate (sitting, crawling, walking, talking)? ☐ Normal ☐ Delayed

Has your child had any of the following illnesses?

	Yes	**No**
Chicken pox	☐	☐
RSV	☐	☐

Has your child been vaccinated? **Yes** ☐ **No** ☐

	Yes	**No**	**Age of Onset**	**Number of Times**
Ear infections	☐	☐	_____	_____
Sinus infections	☐	☐	_____	_____
Pneumonia	☐	☐	_____	_____
Croup	☐	☐	_____	_____

Other illnesses ☐ (specify) _____

Has your child been hospitalized? ☐ No ☐ Yes

If Yes, how many times has your child been hospitalized? _____

M M / D D / Y Y Y Y

_____ Reason: _____

_____ Reason: _____

_____ Reason: _____

_____ Reason: _____

_____ Reason: _____

Patient Name:_____ DOB:_____

PAST SURGICAL HISTORY

Has your child had any surgeries? ☐ No ☐ Yes

If Yes, complete the following:

Ear Tube(s): Year _____ Reflux surgery: Year _____ Tonsillectomy: Year _____
Appendectomy: Year _____ Adenoidectomy: Year _____ Hernia Repair: Year _____
Sinus Surgery: Year _____ Other: (specify) _____ Year _____

IMMUNIZATION HISTORY

Are your child's immunizations up to date? ☐ Yes ☐ No (explain) _____

_____

Did your child have a flu shot this year? ☐ Yes

ALLERGY HISTORY

Is your child allergic to foods? If Yes, mark all that apply.

☐ Milk ☐ Egg ☐ Soy ☐ Wheat ☐ Peanuts ☐ Tree nuts (i.e. walnuts, pecans, etc.)
☐ Shellfish ☐ Fish ☐ Other (specify) _____

_____

_____

	Yes	No	Unknown
Is your child allergic to animals? ☐ Cats ☐ Dogs ☐ _____	☐	☐	☐
Is your child allergic to medications?	☐	☐	☐
Specify _____			
_____			
Is your child allergic to ☐bee ☐ wasp ☐ yellow jacket ☐ hornet sting?	☐	☐	☐
Is your child allergic to ☐ ant stings? ☐mosquitoes?	☐	☐	☐
Does your child have ☐atopic dermatitis ☐ eczema?	☐	☐	☐
Does your child have frequent hives or swelling?	☐	☐	☐
Does your child have nasal allergies?	☐	☐	☐
If Yes, when? (mark all that apply) ☐ Spring ☐ Summer ☐ Fall ☐ Winter			
Does your child have eye symptoms from allergies?	☐	☐	☐
If Yes, when? (mark all that apply) ☐ Spring ☐ Summer ☐ Fall ☐ Winter			

FAMILY MEDICAL HISTORY

Child's Father: Age _____ years Occupation: _____
Does he have any of the following conditions? (mark all that apply)

☐ No allergies ☐ Allergy to animals _____ ☐ Asthma
☐ Food allergy _____ ☐ Hay fever ☐ Insect sting allergy
☐ Latex allergy ☐ Medication allergy_____ ☐ Eczema

Child's Mother: Age _____ years Occupation:_____

Patient Name:_____ DOB:_____

Does she have any of the following conditions? (mark all that apply)

☐ No allergies ☐ Allergy to animals _____ ☐ Asthma
☐ Food allergy_____ ☐ Hay fever ☐ Insect sting allergy
☐ Latex allergy ☐ Medication allergy_____ ☐ Eczema

Child's Brothers/Sisters? Number: _____

Sibling 1: Age _____ years ☐ Female ☐ Male

Does he/she have any of the following conditions? (mark all that apply)

☐ No allergies ☐ Allergy to animals _____ ☐ Asthma
☐ Food allergy_____ ☐ Hay fever ☐ Insect sting allergy
☐ Latex allergy ☐ Medication allergy_____ ☐ Eczema

Sibling 2: Age _____ years ☐ Female ☐ Male

Does he/she have any of the following conditions? (mark all that apply)

☐ No allergies ☐ Allergy to animals _____ ☐ Asthma
☐ Food allergy_____ ☐ Hay fever ☐ Insect sting allergy
☐ Latex allergy ☐ Medication allergy_____ ☐ Eczema

Sibling 3: Age _____ years ☐ Female ☐ Male

Does he/she have any of the following conditions? (mark all that apply)

☐ No allergies ☐ Allergy to animals _____ ☐ Asthma
☐ Food allergy_____ ☐ Hay fever ☐ Insect sting allergy
☐ Latex allergy ☐ Medication allergy_____ ☐ Eczema

Does any family member have cystic fibrosis? ☐ Yes ☐ No

Does any family member have any other type of lung disease? ☐ Yes ☐ No

Specify _____

HOME ENVIRONMENTAL HISTORY

What type of dwelling does the child live in? ☐ Apartment ☐ Condo ☐ House ☐ Townhouse ☐ Mobile home ☐ Other (specify): _____

What year was the current residence built? _____ Or age in years _____ years

How long has the child lived in the current residence? _____ Years _____ Months

Is there a basement? ☐ No ☐ Yes (mark all that apply):

☐ Finished ☐ Unfinished ☐ Dry ☐ Damp ☐ Flood damage

What type of heating system does the residence have? (mark all that apply)

☐ Electric baseboard heat ☐ Fireplace ☐ Forced hot air (gas)
☐ Hot water radiator or furnace ☐ Space heater ☐ Wood burning stove

☐ Other (specify): _____

What type of cooling system does the residence have? (mark all that apply)

☐ Central air conditioning ☐ Swamp cooler ☐ Window (room) air conditioning ☐ None

What type of air filtration unit does the residence have? (mark all that apply)

☐ Central air filter ☐ Portable air filter ☐ None ☐ Unknown

What type of humidifier is in the residence? (mark all that apply)

☐ Humidifier on central system ☐ Portable humidifier ☐ None ☐ Unknown

What type of window coverings are there in the residence? (mark all that apply)

☐ Curtains ☐ Venetian blinds ☐ Other (specify) _____

Patient Name:_____ DOB:_____

What type of furnishings does your child's bedroom have? (mark all that apply)

Flooring: ☐ Carpet ☐ Hardwood ☐ Tile ☐ Other (specify): _____

Pillow(s): ☐ Feather ☐ Foam ☐ Polyfill ☐ Other (specify): _____

How old are the pillows? _____ years

Mattress: ☐ Regular ☐ Waterbed ☐ Other (specify): _____

How old is the mattress? _____ years/months

How many stuffed animals are in the bedroom? _____

How many smokers live in the residence? _____

☐ Child (patient) ☐ Father ☐ Mother ☐ Sibling(s)

☐ Other relatives ☐ Other visitors

Do you have pets/animals? (mark all that apply)

☐ Bird(s): number: ____ ☐ Indoor☐ Outdoor☐ Indoor/Outdoor☐ In bedroom

☐ Cat(s): number: ____ ☐ Indoor☐ Outdoor☐ Indoor/Outdoor☐ In bedroom

☐ Dog(s): number: ____ ☐ Indoor☐ Outdoor☐ Indoor/Outdoor☐ In bedroom

☐ Other (specify):

_____: ____ ☐ Indoor☐ Outdoor☐ Indoor/Outdoor☐ In bedroom

_____: ____ ☐ Indoor☐ Outdoor☐ Indoor/Outdoor☐ In bedroom

SOCIAL HISTORY

1. What grade is your child in? _____ ☐ Not applicable
2. Is your child home-schooled? ☐ YES ☐ NO
3. Does your child attend daycare? ☐ YES ☐ NO
   How many hours per week? _____ hours
   How many children are in his/her daycare? _____
4. Does your child have problems in school with learning or with teachers? ☐ Yes ☐ No
5. Is your child in special education classes? ☐ Yes ☐ No
   (If YES, please bring an individualized education plan: IEP)
6. Has your child had psychological testing? ☐ Yes ☐ No
   (If YES, please bring a copy of the report)
7. What are your child's hobbies/interests? _____
8. Does your child have any of the following difficulties or problems?
   a. Making or keeping friends ☐ YES ☐ NO
   b. Paying attention ☐ YES ☐ NO
   c. Overly active ☐ YES ☐ NO
   d. Frequent worrying ☐ YES ☐ NO
   e. Frequent stress ☐ YES ☐ NO
   f. Frequent sadness ☐ YES ☐ NO
   g. Frequent anger or irritability ☐ YES ☐ NO
   h. Taking medications ☐ YES ☐ NO
   i. Fear of medical procedures ☐ YES ☐ NO
9. Has your child ever received any counseling or therapy for any of these problems? ☐ YES ☐ NO
   (If YES, which one(s)? _____

10. Has your child ever received any medication for any of these problems? ☐ YES ☐ NO
    (If YES, which one(s)? _____
11. Has your child's illness caused excessive stress or disruptions for the family? ☐ YES ☐ NO
12. Do you think your child has a problem sleeping? ☐ YES ☐ NO
    (If YES, is this related to your child's health (e.g., itching, wheezing, pain)? ☐ YES ☐ NO

HEALTH PROBLEMS (REVIEW OF SYSTEMS)

General Symptoms ☐ Fatigue ☐ Fever/chills ☐ Trouble sleeping ☐ Loss of appetite
☐ Other (specify): _____

Eyes ☐ Blurred vision ☐ Burning ☐ Cataracts ☐ Frequent blinking
☐ Far-sighted ☐ Itching ☐ Lazy eye ☐ Near-sighted
☐ Redness ☐ Swelling ☐ Watery eyes ☐ Wears glasses
☐ Other (specify): _____
Date of last eye examination _____month / year

ENT ☐ Change in sense of smell ☐ Dry mouth ☐ Ear pain
☐ Enlarged lymph nodes ☐ Hearing loss ☐ Hoarseness/change in voice
☐ Itchy eyes ☐ Itchy nose ☐ Mouth breathing ☐ Mouth sores
☐ Nasal congestion ☐ Nasal drainage ☐ Nasal polyps ☐ Nosebleeds
☐ Post-nasal drip ☐ Sinus congestion ☐ Sneezing ☐ Snoring
☐ Sore throat ☐ Stridor ☐ Throat tightness
☐ Other (specify): _____

Speech ☐ Delay/Impediment ☐ Slurred ☐ Stuttering
☐ Other (specify): _____

Heart ☐ Chest pain ☐ Dizziness ☐ Murmurs ☐ Fainting spells
☐ Irregular heartbeat ☐ Palpitations
☐ Other (specify): _____

Lungs ☐ Chest tightness ☐ Cough-nonproductive/dry ☐ Cough productive (phlegm)
☐ Cough at night ☐ Coughing up blood ☐ Frequent bronchitis/chest colds
☐ Wheezing ☐ Shortness of breath-daytime ☐ Shortness of breath-nighttime
☐ Shortness of breath-exercise or vigorous play ☐ Low oxygen levels
☐ Other (specify): _____

GI ☐ Abdominal pain/stomach ache ☐ Bloody stool ☐ Bloating ☐ Burping
☐ Choking on food/drink ☐ Constipation ☐ Diarrhea ☐ Gassiness
☐ Heartburn/acid taste in mouth ☐ Indigestion ☐ Nausea ☐ Vomiting
☐ Regurgitation/spitting up ☐ Trouble swallowing
☐ Other (specify): _____

Feeding and Nutrition:

Do you have any concerns about your child's weight or height?

☐ Weight loss ☐ Poor weight gain ☐ Too short ☐ Too thin ☐ Overweight

Does the child have?

Difficulty feeding? ☐ Yes ☐ No Loss of appetite? ☐ Yes ☐ No

Food avoidance? ☐ Yes ☐ No

If yes, does the child avoid or refuse particular foods?

☐ Milk ☐ Egg ☐ Wheat ☐ Soy ☐ Peanut ☐ Tree nuts

☐ Fish ☐ Shellfish ☐ Others:_____

Does the child avoid certain textures or types of foods?:

☐ Soft/mushy texture ☐ Crunchy texture ☐ Bolus foods (e.g. meats/breads)

☐ Spicy foods ☐ Others: _____

Does the child cough or choke/gag when eating or drinking?

Liquids ☐ Yes ☐ No Solids ☐ Yes ☐ No

Others: _____ ☐ Yes ☐ No

Genitourinary ☐ Bedwetting ☐ Wetting pants ☐ Encoporesis (soiling pants)

☐ Frequent urination ☐ Painful urination ☐ Menses: Onset: ____ years

☐ Other (specify) _____

Muscles and Bones ☐ Fractures ☐ Back pain ☐ Joint pains ☐ Muscle pain

☐ Muscle weakness ☐ Other (specify) _____

Neurologic ☐ Concentration problems ☐ Difficulty walking ☐ Headaches

☐ Numbness ☐ Tremors ☐ Seizures ☐ Weakness

☐ Other (specify) _____

Skin ☐ Easy brusing ☐ Eczema ☐ Hair loss ☐ Hives/welts ☐ Infections

☐ Itching ☐ Lumps ☐ Rashes ☐ Other (specify) _____

Blood Diseases ☐ Anemia ☐ Easy bruising ☐ Bleeding tendency ☐ Hemophilia

☐ Sickle Cell Anemia ☐ Other (specify) _____

Sleep ☐ Excessive daytime sleepiness ☐ Difficulties falling asleep ☐ Multiple night awakenings

☐ Frequent or loud snoring ☐ Stopping breathing during sleep ☐ Morning headaches

☐ Restless sleep (kicking, jerking, twitching) ☐ Difficulty waking in the morning

☐ Discomfort or pain in legs at bedtime/during the night ☐ Other (specify) _____

MEDICATIONS

What medications does your child take?

Medication Name	Dose	Route	How Often	Description
Steroid Inhalers				
☐ Aerobid (Arrow-Bid)				gray w/a purple cap (mdi)
☐ Aerobid (Arrow-Bid)				light green w/a dark green cap (mdi)

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☐ Azmacort (Asthma-Court)				white w/a white cap 7 extension (mdi)
☐ Asmanex				white w/a pink bottom ring 7 counter (twisthaler)
☐ Flovent (Flow-Vent)				orange w/an orange cap (mdi)
☐ Pulmicort (Pull-Mih-Court)				white w/bottom brown ring in a turbuhaler or flexhaler or tube
☐ Pulmicort (Pull-Mih-Court)				respules containing liquid for nebulizer
☐ Qvar				brown or burgundy depending on dose w/gray cap

Medication Name	Dose	Route	How Often	Description
Fast-acting Inhalers				
☐ Albuterol (Al-Bew-Ter-All)				white w/white cap (mdi)
☐ Ventolin (Ven-Toe-Lin)				light blue w/dark blue cap & counter (mdi)
☐ Alupent (Al-You-Pent)				clear w/blue cap (mdi)
☐ Atrovent (At-Row-Vent)				clear w/green cap (mdi)
☐ Proair (Pro-Air)				red w/white cap (mdi)
☐ Proventil (Pro-Vent-Ill)				yellow w/orange cap (mdi)
☐ Maxair (Max-Air)				light blue (autohaler)
☐ Xopenex (Zo-Pin-Ex)				light blue w/red cap (mdi)
☐ Combivent				clear w/orange cap
☐ Primatene Mist				
Long-acting Bronchodilators				
☐ Foradil (For-A-Dill)				blue cap covers a white tube w/a blue bottom. Insert pill into tube and pierce pill (aerolizer)
☐ Serevent (Sara-Vent)				green w/counter (diskus)
☐ Spiriva (Spy-Reev-Ah)				oval device gray base w/green piercing button. Need to load pill into oval device (handihaler)
Combination Medications (Inhaled Steroid and Long Acting Bronchodilator)				
☐ Advair (Add-V-Air)				purple disc w/counter (diskus)
☐ Symbicort (Sim-By-Court)				red w/gray cap (mdi)
Leukotriene Modifying Agents				
☐ Singulair (Sing-Yule-Air)				pink or tan pill
☐ Accolate (Ac-Coal-Aid)				white pill

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☐ Zyflo (Z-Eye-Flow)				white pill (big)
Oral Steroids				
☐ Prednisone, Deltasone, Medrol				white pill
☐ Prelone, Pediapred, Orapred				liquid
Other Medications				
☐ Xolair (Zo-L-Air)				
☐ Allergy Shots				
☐ Intal				white w/blue cap (mdi)
☐ Tilade				white w/white cap (mdi)

Medication Name	Dose	Route	How Often	Description
Antihistamines				
☐ Allegra				
☐ Benadryl				
☐ Hydroxyzine				
☐ Clarinex				
☐ Claritin				
☐ Xyzal				
☐ Zyrtec				
Nose Spray				
☐ Saline				
☐ Astelin				
☐ Flonase				
☐ Nasacort AQ				
☐ Nasonex				
☐ Rhinocort AQ				
☐ Veramyst				
☐ Zantac/Ranitidine				
☐ Proton pump inhibitors				
☐ Epipen				
☐ Ointments				
☐ Others				

Patient Name:_____ DOB:_____