Prana Health
Ad Vitam - For Life

PEDIATRIC ASTHMA QUESTIONNAIRE

Name: _____ Date: _____
Date of Birth: _____ Referring Physician: _____

Chief Complaint:
□ Shortness of breath □ Cough □ Asthma □ Congestion of nose □ Chest tightness □ Throat tightness
□ Other (Please describe):_____

Date Symptoms First Noted: _____
□ Worse at night □ Worse during the day □ Problem during the day and night

Frequency of symptoms:
A. Daytime Symptoms:
□ Less than twice a week □ Two or more days in a week □ Every day
B. Nighttime Symptoms:
□ Less than once a month □ 1-2 times a month □ more than 2 times a month
□ more than once a week □ more than twice a week □ more than four times a week
□ every night
C. Use of Rescue Inhaler:
□ less than two days a week □ more than two days a week □ several times a day

Have you/ your child has had any **PREVIOUS ALLERGY TESTING?**
□ NONE □ YES (if yes continue below)
Date: _____ Positive to: _____
Previous Allergy Injections □ NO □ YES
Previous Injection Dates: _____ Last Injection: _____

NASAL AND EYE SYMPTOMS: Please check all which apply
□ **NONE**
□ Nasal Stuffiness □ Sneezing □ Post Nasal Drip □ Itchy Nose □ Itchy Eyes
□ Headache □ Ear Problems □ Other: _____
Nasal Discharge: □ NONE □ Clear □ White □ Yellow □ Green
When is the child most symptomatic? □ Winter □ Spring □ Summer □ Fall □ Year-Round
Suspected or known causes of these symptoms
□ Colds □ Dust □ Odors/Fumes □ Cigarette Smoke
□ Trees □ Weeds □ Grass □ Mold
□ Dogs □ Cats □ Latex □ Foods □ Other
Number of Sinus Infections treated in the past year: □ NONE □ 1-2 □ 3-4 □ 5 or more
Did you have a Sinus X-ray? □Yes □ No Date: _____
Did you have a Sinus Cat Scan? □Yes □ No Date: _____
History of Nasal Polyps? □Yes □ No

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SKIN PROBLEMS: Please check all which apply

□ NONE □ Eczema □ Hives □ Rash □ Other _____

Did any of the following occur around the time of onset of the rash?

□ Change in medications □ Extended Farm Visit □ Change in diet
□ Viral infection /cold □ Change in cosmetics □ Change in detergent, soap, shampoo, etc.
□ Change in home/work environment

SLEEP HISTORY: Please check all which apply:

A. NIGHTIME SYMPTOMS:

☐ The child snores? If the child snores, is it: ☐ Mild ☐ Moderate ☐ Loud ☐ Very Loud
If yes, is it ☐ Every Night ☐ Usually ☐ Sometimes ☐ Don't Know
☐ The child stops breathing while sleeping ☐ The child "struggle" to breathe while sleeping
☐ The child has "loud breathing" while sleeping ☐ The child has snorting or gasping while sleeping
☐ The child breathe through mouth while sleeping ☐ The child sleeps in abnormal positions
☐ Bedwetting ☐ Nasal Congestion ☐ Drooling of saliva on pillows

B. DAYTIME SYMPTOMS

☐ The child has poor sleep and feels ☐ Tired ☐Sleepy ☐Groggy ☐Exhausted
☐ The child wake up with a headache ☐ The child has trouble at school because of sleepiness
☐ The child gets late to school frequently ☐ The child has trouble concentrating
☐ The child has hyperactivity/behavioral problems ☐ The child's grades are declining

PAST MEDICAL HISTORY

☐ High blood pressure ☐ ADHD ☐ Depression ☐ Anxiety☐ Acid reflux ☐ Head Injury ☐ Seizures
☐ Iron deficiency ☐ Others: _____

Surgical history: List all surgeries that the child has had and approximate dates if possible:

1. _____
2. _____
3. _____

FAMILY HISTORY: Please check all which apply

☐ Asthma ☐ Allergies ☐ Sleep apnea ☐ Major illnesses in parents and siblings (please describe)_____

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PERSONAL, SOCIAL and ENVIRONMENTAL HISTORY

☐ Living with parent (s): ☐ The child has sibling (s) (how many)_____
☐ Special education program ☐ Smoking ☐ Alcohol ☐ Recreational drug
Grade:_____

List **ALL SMOKERS** who live in the home _____
List **ALL ANIMALS** in or around the home _____
Pets allowed in bedroom? ☐ YES ☐ NO
DWELLING TYPE: ☐ House ☐ Apartment ☐ Condo ☐ Townhouse ☐ Basement Apartment
HEATING SYSTEM: ☐ Forced Hot Air ☐ Electric Baseboard ☐ Hot Water Baseboard
☐ Radiator ☐Wood Burning Stove ☐ Other _____
BEDROOM: ☐ Winter bedroom temperature: _____ Allergy covers? ☐YES ☐ NO
Type of Pillow: ☐ Synthetic ☐ Feather
Bedding: ☐ Feather Bed ☐ Feather Comforter
Description of Bedroom: ☐ Neat ☐ Cluttered ☐ Dusty ☐ Stuffed Toys
AIR CONDITIONING: ☐ NONE ☐ Window ☐ Central
AIR FILTER: ☐ NONE ☐ Room ☐ Central

MEDICATIONS:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

ALLERGIES:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

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REVIEW OF SYSTEMS: (PLEASE CHECK ALL THAT APPLY TO YOU):

General: ☐ Weight Loss ☐Weight Gain ☐Night Sweats
Eyes: ☐ Decreased vision ☐Double Vision ☐Wears Glasses
Ears: ☐Decreased hearing ☐Ear Infections ☐Ringing in the ears
Cardiovascular: ☐Chest pain ☐Palpitation/ irregular heart beat ☐Murmur ☐Leg Swelling
Gastrointestinal: ☐Constipation ☐Colic
Genitourinary: ☐Bedwetting ☐Frequent urination at night
Musculoskeletal: ☐Joint Pains
Skin: ☐Easily bruised ☐Rash
Neurological: ☐Weakness ☐Numbness and Tingling ☐Frequent headaches ☐Neuropathy
Psychiatric: ☐Anxiety ☐Depression
Endocrine: ☐Thyroid disease ☐Diabetes ☐Precocious puberty
Hematopoietic: ☐Anemia (low blood count) ☐ Bleeding tendency
GIRLS ONLY: ☐Irregular periods ☐Pregnant ☐Using contraceptives *(some medications used in treating sleep disorders can impair the effectiveness of certain contraceptives)*

Pediatric Epworth Sleepiness Scale (ESS)

How LIKELY is the child likely to DOZE OFF or FALL ASLEEP in the following situations, in contrast to feeling tired? This refers to the child's usual way of life in recent times (within the last 6 months or last year). Even if the child has not done some of these things recently, try to work out how they would have affected the child.

0 = Would NEVER doze
1 = SLIGHT chance of dozing
2 = MODERATE chance of dozing
3 = HIGH chance of dozing

Situation	**Chance of Dozing**
Sitting and reading……	0 1 2 3
Watching TV……	0 1 2 3
Sitting inactive in a public place (i.e. theater or meeting)……	0 1 2 3
As a passenger in a car without a break……	0 1 2 3
Lying down in the afternoon when circumstances permit……	0 1 2 3
Sitting and talking to someone……	0 1 2 3
Sitting quietly after lunch ……	0 1 2 3
Playing Video games……	0 1 2 3

TOTAL _____

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Patient Health Questionnaire (PHQ-9)

DEPRESSION SCREEN (FOR CHILDREN> 12 years)

1. Over the *last 2 weeks,* how often have you been bothered by any of the following problems?

	Not at all	Several days	More than half the days	Nearly every day
a. Little interest or pleasure in doing things	0	1	2	3
b. Feeling down, depressed, or hopeless	0	1	2	3
c. Trouble falling/staying asleep, sleeping too much	0	1	2	3
d. Feeling tired or having little energy	0	1	2	3
e. Poor appetite or overeating	0	1	2	3
f. Feeling bad about yourself or that you are a failure or have let yourself or your family down	0	1	2	3
g. Trouble concentrating on things, such as reading the newspaper or watching tv.	0	1	2	3
h. Moving or speaking so slowly that other people could have noticed. Or the opposite; being so fidgety or restless that you have been moving around a lot more than usual.	0	1	2	3
i. Thoughts that you would be better off dead or of hurting yourself in some way.	0	1	2	3
ADD COLUMNS: _____ + _____ + _____ + _____				
TOTAL: _____				

2. If you checked off any problem on this questionnaire so far, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

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Generalized Anxiety Disorder 7-item (GAD-7) scale

Over the las 2 weeks, how often have you been bothered by the following problems?	Not at all sure	Several days	Over half the day	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it's hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3
Add the score for each column	_____	_____	_____	_____

Total Score =_____

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all_____
Somewhat difficult_____
Very difficult_____
Extremely difficult_____