Children's Lung, Asthma & Sleep Specialists
2660 W. Fairbanks Avenue, Winter Park, FL 32789
Phone: 407-898-2767 - Fax: 407-898-9443 - Toll Free 866-383-0556 - Toll Free Fax 877-898-9443
Akinyemi Ajayi, MD, D.ABSM - Kimberly K. Justice, Ph.D. Lic. Psychologist

Date: _____

PATIENT INFORMATION

Child's Name: _____ Sex ____ DOB_____ Age _____

Address: _____
Street City County State Zip

Child's racial/ethnic background: ☐ White/Caucasian ☐ Black/African-American ☐ Asian-American ☐ Other
☐ Native-American ☐ Hispanic-Latino ☐ Multi-racial

Who referred your child? _____
Name Address

Briefly describe any behavioral issues your child presently is experiencing or has experienced in the past (how often, duration, severity, and how you have handled it). When did you first become concerned?:

_____

_____

_____

_____

What are your concerns regarding your child's sleep? What have you done to try to correct the situation?

_____

_____

_____

FAMILY HISTORY

Father's name: _____ Age: _____

Address (if different from above): _____
Street City County State Zip

Education: _____Occupation: _____Work Schedule:□ Part-time □Full-time □ Unemployed

Mother's name: _____ Age: _____

Address (if different from above): _____
Street City County State Zip

Education: _____Occupation: _____Work Schedule: □Part-time □Full-time □ Unemployed

PERSONS LIVING IN HOME		
Name:	Relationship	Age

Date of Marriage: _____

Present marital status: ☐ Single ☐ Divorced ☐ Separated ☐ Married ☐ Widowed ☐ Remarried

Child lives with: ☐ Mother ☐ Father ☐ Step-mother ☐ Step-father ☐ Adoptive parents ☐ Other (specify)_____

If parents are divorced or separated: Date of separation/divorce _____

Custody arrangement: _____ Visitation/Contact schedule: _____

PRENATAL/BIRTH HISTORY

Pregnancy and birth. Any complications? ☐ Yes ☐ No If yes, please explain:_____

_____

Medication(s) taken during pregnancy: _____

Use of Tobacco/Alcohol/Other drugs: _____

Length of Gestation (months): _____ Delivery Type: (e.g., vaginal, c-section): _____

Birth weight:_____ Birth length: _____ APGAR scores: _____

Any problems with:

Pregnancy: ☐ Yes ☐ No Labor: ☐ Yes ☐ No Delivery: ☐ Yes ☐ No Jaundice: ☐ Yes ☐ No

If yes, please explain: _____

DEVELOPMENTAL HISTORY

Developmental Milestones:

Turn over _____ Sat up alone _____ Crawl _____Walked _____ Spoke single words _____

Talked in Sentences _____ Weaned (bottle or breast – specify) _____Toilet Trained – Days _____ Nights _____
If problems, specify _____

Growth and development:

Does your child have any problems with growth or development? ☐ Yes ☐ No If yes, please explain:_____ How does your child compare with other children of the same age?_____ Is your child delayed in any of the following skills?

Motor skills ☐ Yes ☐ No Sensory/Communication Skills (e.g., vision, hearing, speech) ☐ Yes ☐ No

Has your child ever had a weight problem? ☐ Yes ☐ No If yes, please explain: _____

Feeding History:

Was your baby: breast fed ☐ Yes ☐ No formula fed ☐ Yes ☐ No If yes, name of formula: _____

Age solids were introduced: _____ Describe your child's current diet _____

Does your child have a good appetite? _____ Does your child have any problems with coughing, gagging, or choking with eating or drinking?_____ Does your child have any problems with spitting up, vomiting, or stomachaches?_____

CURRENT MEDICAL HISTORY		
Please list any medications your child currently takes:		
Medicine	Dose	How often?
1.		

2.

3.

4.

Please list any medications your child is allergic to:

1.

2.

Any food or environmental allergies? ☐ Yes ☐ No Date of testing: Test type: skin or blood

Has your child had any allergy testing?

Are your child's immunizations up-to-date? ☐ Yes ☐ No

Has your child had a TB test? ☐ Yes ☐ No PDD test? ☐ Yes ☐ No Tine Test? ☐ Yes ☐ No

Date of test: Results:

LONG-TERM MEDICAL PROBLEMS

If your child has long-term medical problems, please list the three you think are most important.

1.

2.

3.

SURGERIES/HOSPITALIZATIONS

Has your child ever had his/her tonsils removed?	☐ Yes	Age at surgery:
Has your child ever had his/her adenoids removed?	☐ Yes	Age at surgery:
Has your child ever had ear tubes?	☐ Yes	Age at surgery:

Please list any additional hospitalizations or surgeries:

HEALTH HABITS

Does your child drink caffeinated ☐ No ☐ Yes Amount per day:

beverages? (e.g.Coke,Pepsi,Mountain Dew, iced tea)			
Do any family members smoke	☐ No	☐ Yes	
Are there pets in the home?	☐ No	☐ Yes	Type:
Do you live in a house or apartment? (circle one)	Age of building:		How long have you lived there?
Type of heating in the home?			
Do you have fans?	☐ No	☐ Yes	
Do you have an air condition unit?	☐ No	☐ Yes	
Or window unit	☐ No	☐ Yes	
If the house dusty?	☐ No	☐ Yes	
Do you have a damp basement?	☐ No	☐ Yes	
Does your child's room have carpet?	☐ No	☐ Yes	
Stuffed animals or feather pillows/down comforter?	☐ No	☐ Yes	

PAST MEDICAL HISTORY

Frequent nasal congestion	☐ Yes	Age of diagnosis:
Trouble breathing through his/her nose	☐ Yes	Age of diagnosis:
Sinus problems	☐ Yes	Age of diagnosis:
Chronic bronchitis or cough	☐ Yes	Age of diagnosis:
Joint/Bones or Muscle problems	☐ Yes	Age of diagnosis:
Asthma	☐ Yes	Age of diagnosis:
Frequent colds or flu's	☐ Yes	Age of diagnosis:
Frequent ear infections	☐ Yes	Age of diagnosis:
Frequent strep throat infections	☐ Yes	Age of diagnosis:
Difficulty swallowing	☐ Yes	Age of diagnosis:
Acid reflux (gastroesophageal reflux)	☐ Yes	Age of diagnosis:
Poor or delayed growth	☐ Yes	Age of diagnosis:
Excessive weight	☐ Yes	Age of diagnosis:
Hearing problems	☐ Yes	Age of diagnosis:
Speech problems	☐ Yes	Age of diagnosis:
Vision problems	☐ Yes	Age of diagnosis:
Seizures/Epilepsy	☐ Yes	Age of diagnosis:
Morning headaches	☐ Yes	Age of diagnosis:

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Cerebral palsy	☐ Yes	Age of diagnosis:
Heart disease	☐ Yes	Age of diagnosis:
High blood pressure	☐ Yes	Age of diagnosis:
Sickle cell disease	☐ Yes	Age of diagnosis:
Genetic disease	☐ Yes	Age of diagnosis:
Chromosome problem (e.g., Down's)	☐ Yes	Age of diagnosis:
Skeleton problem (e.g., dwarfism)	☐ Yes	Age of diagnosis:
Cranofacial disorder (e.g., Pierre-Robin)	☐ Yes	Age of diagnosis:
Thyroid problems	☐ Yes	Age of diagnosis:
Eczema (itchy skin)	☐ Yes	Age of diagnosis:
Pain	☐ Yes	Age of diagnosis:
Throat problems	☐ Yes	Age of diagnosis:
Kidney problems	☐ Yes	Age of diagnosis:
Poor Appetite/Diet	☐ Yes	Age of diagnosis:
Urinary/Bladder problems/accidents	☐ Yes	Age of diagnosis:
Bowel problems/accidents	☐ Yes	Age of diagnosis:

FAMILY MEDICAL HISTORY			
Apnea	☐ Yes	☐ No	Relationship to child:
Asthma	☐ Yes	☐ No	Relationship to child:
Bronchitis	☐ Yes	☐ No	Relationship to child:
Chronic cough	☐ Yes	☐ No	Relationship to child:
Tuberculosis	☐ Yes	☐ No	Relationship to child:
SIDS/crib death	☐ Yes	☐ No	Relationship to child:
Cystic Fibrosis	☐ Yes	☐ No	Relationship to child:
Emphysema	☐ Yes	☐ No	Relationship to child:
Pneumonia	☐ Yes	☐ No	Relationship to child:
Hayfever/Allergies	☐ Yes	☐ No	Relationship to child:
Sacoidosis	☐ Yes	☐ No	Relationship to child:
Sickle Cell Disease	☐ Yes	☐ No	Relationship to child:

FAMILY PSYCHIATRIC/PSYCHOLOGICAL HISTORY			
Autism	☐ Yes	☐ No	Relationship to child:
Developmental delay	☐ Yes	☐ No	Relationship to child:
Hyperactivity/ADHD	☐ Yes	☐ No	Relationship to child:
Anxiety/Panic Attacks	☐ Yes	☐ No	Relationship to child:
Obsessive Compulsive Disorder	☐ Yes	☐ No	Relationship to child:
Depression	☐ Yes	☐ No	Relationship to child:
Suicide	☐ Yes	☐ No	Relationship to child:
Bipolar Disorder	☐ Yes	☐ No	Relationship to child:
Learning disability	☐ Yes	☐ No	Relationship to child:
Drug use/abuse	☐ Yes	☐ No	Relationship to child:
Behavioral disorder	☐ Yes	☐ No	Relationship to child:
Psychiatric Admission	☐ Yes	☐ No	Relationship to child:

Please list any additional psychological, psychiatric, emotional, or behavioral problems diagnosed or suspected by a physician/psychologist regarding your child.

SCHOOL PERFORMANCE

CURRENT SCHOOL PERFORMANCE (if school-aged)

Your child's grade:		Name of school your child attends:			
Has your child ever repeated a grade?	☐ No	☐ Yes			
Is your child enrolled in any special education class?	☐ No	☐ Yes			
How many school days has your child missed so far this year?					
How many school days did your child miss last year?					
How many school days was your child late so far this year?					
How many school days was your child late last year?					
Child's grades this year:	☐ Excellent	☐ Good	☐ Average	☐ Poor	☐ Failing
Child's grades last year:	☐ Excellent	☐ Good	☐ Average	☐ Poor	☐ Failing

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Any current or past academic/behavioral problems in school? (specify)

SOCIAL HISTORY

How many close friends does your child have?

_____

How many close friends does your child have in your neighborhood?

_____

How many times a week does your child do something with friends? _____

Compared to other children his/her age, how well does your child get along with other children?

_____

List any jobs or chores your child is responsible for at home?

_____

_____

What are your child's extracurricular activities and hobbies?

_____

_____

Pets? _____

Usual Disciplinary Techniques used with your child? _____

_____

Are they effective? _____

Who generally disciplines your child? _____Do parents agree on methods of discipline? _____

ABUSE/TRAUMA HISTORY

Has your child ever been physically/sexually/emotionally abused? ☐ Yes ☐ No

If yes, please explain:_____

_____

_____

Has your child ever been exposed to domestic violence? ☐ Yes ☐ No

If yes, please explain: _____

_____

Has your child ever experienced any other severe trauma (e.g. car accident, physical accident)? ☐ Yes ☐ No

If yes, please explain: _____

Form completed by:

Print First Name Last Name Signature relationship date