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Patient Name: _____ **DOB:** _____

Who referred you to our practice? _____

Other doctors involved in your care:

Was patient ever seen by a pulmonologist before? Yes No

Please explain the reason for today's visit:

Please list all current medications and dosage, if taking daily or as needed and how long on current medication:
(Please include prescription and over-the-counter medications)

List any known drug/food/environmental allergies and the reaction from exposure: Is there a history of allergy testing? Yes No

BIRTH HISTORY:

Was the pregnancy full term? Yes No If premature, how many weeks at birth? _____ weeks

Delivery: Vaginal Cesarean Birth Weight _____

Were there any complications with the patient after birth? Yes No If yes, please explain:

Was patient in the NICU? Yes No If yes, how many days/weeks? _____ days/weeks

Was the infant on a ventilator/CPAP in the NICU? Yes No How long? _____ days/weeks

How long was patient on oxygen, if any? _____ days/weeks/months

PAST MEDICAL HISTORY:

Has patient ever been hospitalized? (Please list surgeries) Yes No If yes, please give dates and reason for hospitalization.

Has patient experienced any of the symptoms listed or ever been diagnosed with any of the following? Please check YES or NO.
If yes, please explain in space provided.

	Yes	No		Yes	No		Yes	No
NEUROLOGIC			NOSE/THROAT			Cardiac		
Eizures			Nosebleeds			Murmurs		
Migraines			Enlarged adenoids			Congenital defects		
ADD/ADHD			Enlarged tonsils			Chest pain		
MUSCULOSKELETAL			Hoarseness			Gastrointestinal		
scoliosis			RESPIRATORY			Reflux		
Weakness			Asthma/RAD			Heartburn		
Hypotonic			BPD			Trouble swallowing		
Muscle disease			Tracheomalacia			Weight issues		
KIDNEY			Laryngomalacia			Endocrine		
Eczema			Croup			Diabetes		
Seizures			Bronchitis			Growth issues		
YES/EARS			Bronchiolitis/RSV			Psychosocial		
Chronic ear infections			Chronic cough			Depression		
Glaucoma			Pneumonia			Anxiety		

Please list any other symptoms/diseases not listed above:

Is patient up to date on immunizations? Yes No If no, what was missed? _____

Family Medical History: Does anyone in the family have a history of asthma/chronic cough/allergies? Yes No
If yes, please list:

Social/Environmental:

Who does patient live with? _____

Are there any smokers in the home? Yes No Does patient attend daycare/school? Yes No

Does patient participate in any sports? Yes No Please list _____

Does patient have any cough, wheeze, shortness of breath with exercise? Yes No

Are there any pets? Yes No If yes, please list:

What kind of heating is in the home? _____

Occupation of Mother: _____ Father: _____

Is there anything else you want us to know about the patient not addressed above that may impact his/her care?

Person completing form _____
Print Name

Signature

Relationship to patient _____

Date _____

Form reviewed by: _____
M. Bye MD J. Horsey CPNP M. Hewitt CPNP J. Honey CPNP

Date _____