Nutmeg Pediatric Pulmonary Services, LLC

Regina M. Palazzo, M.D.

Kelly Sosensky, APRN

Dear Patient:

Please complete the enclosed information and either fax it back to us or bring it with you on the day of your appointment, along with the following:

- **Chest x-rays** if obtained within six months. Please bring disc.
- **Health insurance card**
- **Photo ID**
- **Co-pay** required by your insurance company is due at the time of service.
- **Medications**: Please bring all medications with directions to each visit. Please remember your PEAK FLOW METER AND SPACER.

If the patient has an insurance plan that requires a referral from the primary pediatrician, please arrange to have the referral in our office prior to the appointment. Patients who do not have the appropriate referrals or co-pays cannot be seen and will be asked to reschedule the appointments. Also please be aware that breathing tests will extend the amount of time needed for the visit. Please plan accordingly.

Please note that we have two locations.

Mondays only
L&M Hospital
365 Montauk Avenue
New London, CT 06320

Tuesday through Friday
Stony Creek Medical Center
6 Business Park Drive Suite 202
Branford, CT 06405

Our office can be contacted Monday through Friday at (203) 208-2395 should you have any questions regarding your appointment.

Sincerely,

MaryAnne Rode
Office Manager

6 Business Park Drive, Suite 202 Branford, CT 06405
365 Montauk Avenue New London, CT 06320
Phone (203) 208-2395 Fax (203) 433-4638

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Referred by:_____ Today's date:_____

Child's name_____ Likes to be called (nickname)_____

Child's school and grade_____

Reason for today's visit_____

_____

Section 1

a) Please circle all the symptoms that apply to your child
   Coughing Wheezing Shortness of Breath Chest tightness or pain
b) How often do symptoms occur: during the day_____ at night?_____

   at home?_____ at school?_____ with exercise?_____
c) Time of year that symptoms occur (please circle all that apply)

   Winter Spring Summer Fall

d) At what age did these symptoms start?_____ Are they improving or getting worse as your child gets older?_____
e) What brings on these symptoms? (Please circle all that apply) Colds Exercise Weather change
   Tobacco smoke Strong odors Medication Dust Mold Pollen
   Foods (specify)_____ Animals (specify)_____

   Other (specify)_____
f) Is your child in daycare? Yes No If yes, how many other children is he/she with?_____
g) What sports does your child play?_____

h) What are your child's hobbies?_____

i) Where does your child go after school? _____

j) How often was your child seen by his/her doctor or in the ER in the last year for these symptoms?_____

   _____
   How many days of school did he/she miss in the past year for these symptoms?_____

k) Has he/she been admitted to the hospital?_____ How many times?_____
l) Has he/she been admitted to the intensive care unit?_____ How many times?_____
   Did he/she need a respirator in the intensive care unit?_____

m) Please list all medications your child uses now or has used._____

_____

_____

Section 2

a) Was your child born on time or pre-term? _____

Were there any problems immediately after the birth?_____

b) Has your child been growing and developing normally?_____

c) Has he/she had any skin rashes?_____ Frequent cold?_____ Runny nose or congestion?_____
Frequent ear infections?_____ sinus infections?_____ Pneumonia?_____ Bronchitis?_____
Bronchiolitis (RSV)?_____ snoring_____ Diarrhea/constipation?_____ vomiting?_____
Stomach pains?_____ Heart problems?_____ neurological problems?_____
Has he/she been tested for allergies?_____ If yes, allergic to?_____
Has he/she been tested for cystic fibrosis? _____ If yes, when and where?_____

Section 3

a) Father's age, ethnic background and occupation_____

b) Mother's age, ethnic background and occupation_____

c) Please specify age and sex of your other children

_____ _____ _____

_____ _____ _____

d) Please list any chronic illnesses that you know of in your family. Please include your children, the grandparents, aunts, uncles, nieces and nephews.

_____

_____

_____

Section 4

a) Home type & age (circle the appropriate type): Apartment(age of building_____)
Single family house (_____ years old) Multi- family house (_____years old)
b) Circle the type of home heating: Oil Gas Forced air Radiators Baseboards other
c) Circle the type of air conditioning: Central Window units None
d) Do you have any of the following: (circle if yes) Humidifier Carpets drapes mold
Stuffed animals cigarette smokers cockroaches mice pets(specify)_____