Nutmeg Pediatric Pulmonary Services, LLC

Regina M. Palazzo, M.D.
Katarzyna M. Saar, D.O.

Dear Patient:

Please complete the enclosed information and bring it with you on the day of your appointment, along with the following:

- **Chest x-rays** if obtained within six months. Please bring actual film or disc.
- **Health insurance membership cards**
- **Photo ID**
- **Co-pay** required by your insurance company is **<u>due at the time of service</u>**.
- **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 appointments. Also please be aware that breathing tests may extend the amount of time needed for the visit. Please plan accordingly.

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

Sincerely,

Jami Klubek
Practice 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

Nutmeg Pediatric Pulmonary Services, LLC

Referred By: ___________________________ Today's Date: ____________________

Patient's Name____

Likes to be called (Nickname): ______________________Date of Birth: _____________________

Reason for today's visit: ____

____

1.) Check ALL the symptoms that apply to the patient:
   a. Coughing Wheezing Shortness of Breath Chest tightness or pain
2.) Do the symptoms occur (check all that apply):
   a. During the day_______ At Night_________
   b. At home__________ At School________
   c. With exercise_____
   d. Where are the symptoms the worst?____________________________
3.) What season do the symptoms occur? (check all that apply):
   a. Winter______
   b. Spring_______
   c. Summer_______
   d. Fall_________
4.) At what age did these symptoms start?___________
5.) As the patient gets older, their symptoms are (Please Check One):
   a. Staying the same_____
   b. Improving__________
   c. Getting Worse________
6.) What triggers these symptoms? (Check all that apply):
   a. Colds______
   b. Exercise_______
   c. Change in the weather___________
   d. Tobacco Smoke____________
   e. Strong Odors____________
   f. Medication_____________
   g. Dust____________
   h. Mold____________
   i. Pollen______________
   j. Foods (be specific) ____
   k. Animals (be specific) ____
   l. Other (be specific) ____
7.) Is the patient in Daycare? Yes____ No_____
   a. If yes, how many other children are there? ____________
8.) What sports does the patient play? ____
9.) What are the patient's hobbies? ____

10.) In the past year, has the patient been seen by their Primary Care Physician or in the Emergency Room for these symptoms?
    a. Yes__________________ No_________________
    b. If yes, how many times?______________
11.) In the past year, how many days of school/work has the patient missed for these symptoms?_____
12.) Has the patient been admitted to the hospital for these symptoms?
    a. Yes______________ No_______________
    b. If Yes, how many times? ___________
13.) Has the patient been admitted to the Intensive Care Unit?
    a. Yes_______________ No________________
    b. If Yes, how many times? __________________
14.) Did the patient require the use of a respirator in the Intensive Care Unit?
    a. Yes________________ No_________________
15.) List all of the patient's current medications: ____
____
____
____
____
16.) List all of the patient's past medications: ____
____
____
____
____

Section 2

1.) Was the patient a full-term pregnancy?
    a. Yes: ____________ No: _____________
    b. If yes, at how many weeks? ______________
    c. Were there any issues immediately after the birth:
        i. Yes_________ No_____________
        ii. If Yes, please explain____
____
____
2.) Has the patient had any kind of surgery?
    a. Yes____________________ No________________
    b. What surgery was performed? ____
    c. Who was the Doctor who performed the surgery? ____________________________________
    d. When was the surgery performed? ____
3.) Has the patient been growing & developing normally? _______________________________________
4.) Has the patient had any of the following? (Check all that apply)
    a. Skin Rashes_______ Frequent Colds_____ Runny Nose_____ Congestion___
    b. Frequent Ear Infections_____ Sinus Infections____ Pneumonia_______
    c. Bronchitis____ Bronchiolitis (RSV)______ Snoring______
    d. Diarrhea/Constipation____ Vomiting____ Stomach Pain____
    e. Heart Problems____ Neurological Problems____

5.) Has the patient had Allergy Testing?
    a. Yes: ________ No: ________
    b. If Yes, what were the results____
    ____
    ____

6.) Has the patient been tested for Cystic Fibrosis?
    a. Yes: _______ No: _______
    b. If Yes, when and where was the testing done?____

Section 3

1) Father's Age, Ethnic Background and Occupation:____
____

2) Mother's Age, Ethnic Background and Occupation:____
____

3) Specify the age of any siblings living in the household:____
____

4) List any Chronic Illnesses that you know of in your family. Include your children, the patient's Grandparents, Aunts, Uncles, Nieces and Nephews:____
____
____
____

Section 4

1.) Home Type:
    a. Apartment______ Age of building___________
    b. Single Family House_______ Year Built________
    c. Multi-Family House________ Year Built________
2.) Check Type of Heating:
    a. Oil_____ Gas_____ Forced Air____ Radiators____ Baseboards____
3.) Check Type of Home Cooling:
    a. Central Air____ Window Units____ None____
4.) Do you have any of the following? (Check all that apply):
    a. Humidifier____ Carpets____ Drapes____ Mold____ Stuffed Animals____ Cigarette Smokers____ Cockroaches____ Mice____
    b. Pets (Be Specific) ____

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Patient Name ____

Nutmeg Pediatric Pulmonary Services, LLC is committed to providing all of our patients with exceptional care. When a patient cancels without providing notice or does not show up for a scheduled appointment, they prevent another patient from being seen.

Appointments not cancelled within 24 hours will be subject to a $50.00 cancellation fee. No Shows are also subject to a $50.00 No Show Fee.

Sign below to consent to these terms:

____
Patient Signature (Parent/Guardian if under 18)

____
Date