MedStar Georgetown
University Hospital

Pediatric Aerodigestive Disorders Clinic

New Patient Questionnaire

Completed By: ________________________ Relationship to Patient: ____________________Date: ________________

Demographic Information

Patient Name: ____
Address: ____
Email: ____
Primary Care Provider (PCP): _______________________

Date of Birth: ____
Phone Number(s): ____
Primary / Secondary Languages: ___________________________
PCP Phone & Fax Numbers: _________________________________

Family Concerns

What are your concerns that you would like to address in your child's evaluation?
____
____
____

Social History

1.) Relationship to child
  a. Biological Child ____ Adoption ____ Foster care____ Surrogacy____
  b. Age at adoption/foster care placement: ____________
  c. Additional Information: ____
2.) Siblings
  a. Yes ____ No ____
  b. Notes: ____

Family Medical History

Relationship to Patient	Medical Condition	Notes

Knowledge and Compassion
Focused on You

Medication & Allergies

Current Medications:

Medication	Dosage	Frequency

Allergies to Medications: ____

Allergies to Food: ____

Hospitalizations, Surgeries, & Procedures

Hospitalizations:

Dates	Reason for admission	Hospital Name

Surgeries & Procedures: *(G-tube placement, EGD, laryngostomy/bronchosopy, speech swallow study, etc.)*

Date	Procedure Performed	Location of Procedure / Physician

Patient Medical History

Birth History

Length of Pregnancy: ____________ Type of Delivery: ________________ Breech position: __________
Birth Weight: ____________________ Birth Height: ____________________ Apgar Scores: _____________

Medications taken during pregnancy: ___________________________

Prenatal exposure: Alcohol ____ Tobacco ____ Drugs ____ Other ____

Complications (explain):____
____
____

Past or Current Medical Conditions:

Yes	No	Does your child experience the following?	If yes, please describe
☐	☐	Recurrent ear infections	
☐	☐	Recurrent colds or sinus infections	
☐	☐	Recurrent ulcers in mouth	
☐	☐	Frequent choking or gagging	
☐	☐	Chronic or recurrent cough	
☐	☐	Pneumonia	
☐	☐	Wheezing	
☐	☐	Environmental allergies	
☐	☐	Heart murmur	
☐	☐	Congenital heart disease	
☐	☐	Appetite change (increase or decrease)	
☐	☐	Nausea and/or vomiting	
☐	☐	Frequent spitting up / regurgitation	
☐	☐	Constipation	
☐	☐	Diarrhea	
☐	☐	Abdominal pain	
☐	☐	Weight loss	
☐	☐	Food allergies	
☐	☐	Urinary tract infections	
☐	☐	Increase or decrease in urination	
☐	☐	Spasticity or hypotonia	
☐	☐	Delay in motor skills	
☐	☐	Delay in speech	
☐	☐	Sensory issues	
☐	☐	Fractures or broken bones	
☐	☐	Skin rash	
☐	☐	Seizures	
		Other:	

Neonatal Questions:

1.) Neonatal Intensive Care Unit (NICU) Admission:
   a. Yes ____ No _______
   b. Hospital: _________________________ Length of Admission: ___________________________

2.) Diagnoses:
   - Retinopathy of prematurity
   - Seizures
   - Intraventricular Hemorrhage (IVH) Grade ___
   - Gastroesophageal Reflux (GERD)
   - Periventricular Leukomalacia (PLV)
   - Difficulty feeding
   - Other: _______________________________________

3.) Interventions:
   - Ventilator / Breathing tube
   - Oxygen tube
   - Physical Therapy
   - Occupational Therapy
   - Speech Therapy
   - Vision Screening
     Results: Pass Fail
   - Hearing Screening
     Results: Pass Fail

Pulmonology Questions:

1.) Bronchopulmonary dysplasia / chronic lung disease:
   a. Yes ____ No ____

2.) Asthma or Reactive airway disease:
   a. Yes ____ No ____
   b. Inhaler ____

3.) Recurrent pneumonia:
   a. Yes ____ No ____
   b. How often? ______________________ Date of last pneumonia: __________

4.) Pulmonary Hypertension:
   a. Yes ____ No ____

5.) Cystic Fibrosis:
   a. Yes ____ No ____

6.) Apnea:
   a. Yes ____ No ____

7.) Pulmonary Procedures:
   a. Bronchoscopy ____
   b. Other: ____________________________

ENT Questions:

1.) Hearing Difficulties:
   a. Yes ____ No ____ Right Ear ____ Left Ear ____ Bilateral ____

2.) Newborn Hearing Screen:
   a. Pass ____ Fail ____

3.) Language and Speech:
   a. Understanding words? Yes ____ No ____
   b. Speaking or pronouncing words? Yes ____ No ____
   c. Enrolled in speech therapy? Yes ____ No ____

4.) Indicate symptoms / conditions your child is experiencing:

☐ Weak voice	☐ Hoarse voice	☐ Gurgly voice
☐ Sneezing	☐ Clear runny nose	☐ Sinus infection requiring antibiotics
☐ Noisy breathing	☐ Floppy airway	☐ Laryngomalacia
☐ Tracheomalacia	☐ Bronchomalacia	☐ Laryngeal cleft
☐ Restless sleeper	☐ Snoring	☐ Gasps or stops breathing during sleep
☐ Vocal cord paralysis	☐ Narrowed airway	☐ Tracheoesophageal Fistula (TEF)

Gastroenterology Questions

5.) Stooling Pattern:
   a. Normal ____ Diarrhea ____ Constipation ____ Blood in stool ____ Mucus in stool ____
   b. Number of stools per day ____

6.) Acid Reflux:
   a. Yes ____ No ____ Medication ____ Name of Medication _______________

7.) Eosinophilic Esophagitis:
   a. Yes ____ No ____ Medication ____ Name of Medication _______________

8.) Feeding Tube:
   a. Yes _____ No _____
   b. G-tube ____ GJ-tube ____ NG-tube____ NJ-tube____
   c. Nissen Fundoplication _____
   d. Size of tube: _____

Nutrition and Speech Therapy Questions:

Feeding Methods:

1.) How does your child currently receive nutrition? Check all that apply:

☐ G-tube ☐ NG-tube ☐ NJ-tube
☐ GJ-tube ☐ Sippy cup ☐ Bottle (nipple types: ________________________)
☐ Open cup ☐ Spoon/fork ☐ Straw
☐ Hands ☐ Other: ________________________

2.) If your child receives tube feedings, please complete the following:

☐ Continuous Feeds:

- Rate: ______ ml/hr
- Duration: _____ hours
- Start time: __________
- End time: ___________

☐ Bolus Feeds:

- Total volume: ______ ml or _____ oz
- Times Given: ___________________
- Feeding duration: __________ minutes

Food Intake:

1.) Please complete the three day diet record attached to the end of this questionnaire if applicable

2.) Indicate the food your child currently takes:

☐ Breast milk ☐ Formula ☐ Pediasure
☐ Soft Chewables ☐ Hard Chewables ☐ Chewy foods
☐ Stage 1 baby food ☐ Stage 2 baby food ☐ Stage 3 baby food
☐ Pureed Table Foods ☐ Other: ________________________

3.) How long does a meal (or for infants, a bottle) usually take? ___________________________________

Food Behaviors:

1.) Does your child display any of the following behaviors related to feeding?

☐ Frequent coughing/choking related to feeding
☐ Gagging/vomiting related to feeding
☐ Refusal behaviors related to feeding (ie: head turning)
☐ Difficulty accepting foods of certain textures
☐ Difficulty chewing
☐ Holding food in mouth
☐ Other: ____

Development:

1.) Please write the age when your child first performed the following skills (circle months or years)

Sat alone: ____________________(Months/Years) Toilet-trained: ___________________ (Months/Years)
Crawled: ____________________ (Months/Years) Learned to Write: ________________(Months/Years)
Walked: ____________________ (Months/Years) Said a single word: _______________(Months/Years)
Babbled: ____________________ (Months/Years) Dressed Self: ______________________(Months/Years)
Used a cup: __________________(Months/Years) Fed self: __________________________(Months/Years)

2.) Does your child use any of the following at home or at school?
☐ Walker ☐ Wheelchair ☐ Special cups/spoons ☐ Pacifier ☐ Sippy cup
☐ Assistive technology ☐ Infant swing ☐ Exersaucer ☐ Infant "walker" or jumper
☐ Other:_______________________

3.) Please list any speech or language difficulties: ____
____

4.) Have your child's language skills regressed? (Lost words, no longer follows directions, etc.) ______________________________
____

5.) Does your child repeat or echo certain words or phrases? ____

School or Early Intervention: *(Complete sections applicable to your child)*

Name:___________________________ City/County______________________________
Grade:___________________________ Approximate # of Students in Class: _____

Teacher(s):____
Support Services: ____

❒ Individual Family Service Plan (IFSP)
❒ Individual Education Plan (IEP)
❒ Adapted PE
❒ Physical therapy
❒ Other: ____
❒ Occupational therapy
❒ Assistive technology
❒ Speech therapy
❒ Classroom aide

❒ Involved in organized activities or sports? _______________________
❒ Any concerns or difficulties?__________________________________

General Behavior: *(Answer questions applicable to your child)*

1.) What are your child's favorite activities? ____________________________
2.) What motivates your child? _____________________________________
3.) How does child play with brothers and sisters? ❒ Poor ❒ Fair ❒ Well ❒ N/A
4.) How does child play with children his/her own age? ❒ Poor ❒ Fair ❒ Well
5.) What is the length of time your child can attend to an activity? _____________
6.) Does your child have any behavior issues? __________________________
7.) Does your child have any attention difficulties? ________________________
8.) Does your child have any repetitive behaviors? (Hand flapping, rocking, lining up toys) _________________________________
9.) Is your child bothered by certain sensations / feelings?
   a. ❒ Noises ❒Textures, clothing, or touch ❒ Movements ❒ Lights
   b. Please Specify: ____

Three Day Food Log – Aerodigestive Disorders Clinic

Please complete this log only if your child eats solid foods

Child's Name:__________________________ **Dates of Food Log:**__________________

Time of Day (i.e., 8:30am)	**Food Items Served to the Child (i.e., Enfamil formula, breast milk, stage 1 applesauce, steamed peas)**	**Amount Child Ate (i.e., 1 ounce, ½ cup, 2 spoonfuls)**	**Amount of time the meal lasted (i.e., 15 min, 45 min)**	**Behavior/Comments** (child's willingness, interest, behaviors, complaints; coughing/choking, vomiting, food pocketing etc.)
	1. 2. 3. 4. 5.	1. 2. 3. 4. 5.		
	1. 2. 3. 4. 5.	1. 2. 3. 4. 5.		
	1. 2. 3. 4. 5.	1. 2. 3. 4. 5.		
	1. 2. 3. 4. 5.	1. 2. 3. 4. 5.		
	1. 2. 3. 4. 5.	1. 2. 3. 4. 5.		
	1. 2. 3. 4. 5.	1. 2. 3. 4. 5.		
	1. 2. 3. 4. 5.	1. 2. 3. 4. 5.		
	1. 2. 3. 4. 5.	1. 2. 3. 4. 5.		

Time of Day (i.e., 8:30am)	**Food Items Served to the Child (i.e., Enfamil formula, breast milk, stage 1 applesauce, steamed peas)**	**Amount Child Ate (i.e., 1 ounce, ½ cup, 2 spoonfuls)**	**Amount of time the meal lasted (i.e., 15 min, 45 min)**	**Behavior/Comments** (child's willingness, interest, behaviors, complaints; coughing/choking, vomiting, food pocketing etc.)
	1. 2. 3. 4. 5.	1. 2. 3. 4. 5.		
	1. 2. 3. 4. 5.	1. 2. 3. 4. 5.		
	1. 2. 3. 4. 5.	1. 2. 3. 4. 5.		
	1. 2. 3. 4. 5.	1. 2. 3. 4. 5.		
	1. 2. 3. 4. 5.	1. 2. 3. 4. 5.		
	1. 2. 3. 4. 5.	1. 2. 3. 4. 5.		
	1. 2. 3. 4. 5.	1. 2. 3. 4. 5.		
	1. 2. 3. 4. 5.	1. 2. 3. 4. 5.		

Time of Day (i.e., 8:30am)	**Food Items Served to the Child (i.e., Enfamil formula, breast milk, stage 1 applesauce, steamed peas)**	**Amount Child Ate (i.e., 1 ounce, ½ cup, 2 spoonfuls)**	**Amount of time the meal lasted (i.e., 15 min, 45 min)**	**Behavior/Comments** (child's willingness, interest, behaviors, complaints; coughing/choking, vomiting, food pocketing etc.)
	1. 2. 3. 4. 5.	1. 2. 3. 4. 5.		
	1. 2. 3. 4. 5.	1. 2. 3. 4. 5.		
	1. 2. 3. 4. 5.	1. 2. 3. 4. 5.		
	1. 2. 3. 4. 5.	1. 2. 3. 4. 5.		
	1. 2. 3. 4. 5.	1. 2. 3. 4. 5.		
	1. 2. 3. 4. 5.	1. 2. 3. 4. 5.		
	1. 2. 3. 4. 5.	1. 2. 3. 4. 5.		
	1. 2. 3. 4. 5.	1. 2. 3. 4. 5.		

.

Submission of Questionnaire

Thank you for completing Georgetown University Hospital's Pediatric Aerodigestive Disorders Clinic questionnaire. Please submit the questionnaire to Lisa Dreyfuss at least 72 hours prior to your child's visit in order for our team to prepare for the evaluation. The questionnaire can be submitted via mail, fax, or email:

By Mail: Lisa Dreyfuss, RN, BSN
Aerodigestive Disorders Clinic
Pediatric Gastroenterology & Nutrition
4200 Wisconsin Avenue NW
Washington, D.C. 20016

By Fax: Georgetown University Hospital
Aerodigestive Disorders Clinic
Pediatric Gastroenterology
Fax: 877-680-5504

By Email: Lisa Dreyfuss, RN, BSN
Lisa.Dreyfuss@gunet.georgetown.edu

For questions call 202-243-3473 or email Lisa Dreyfuss at the above email address