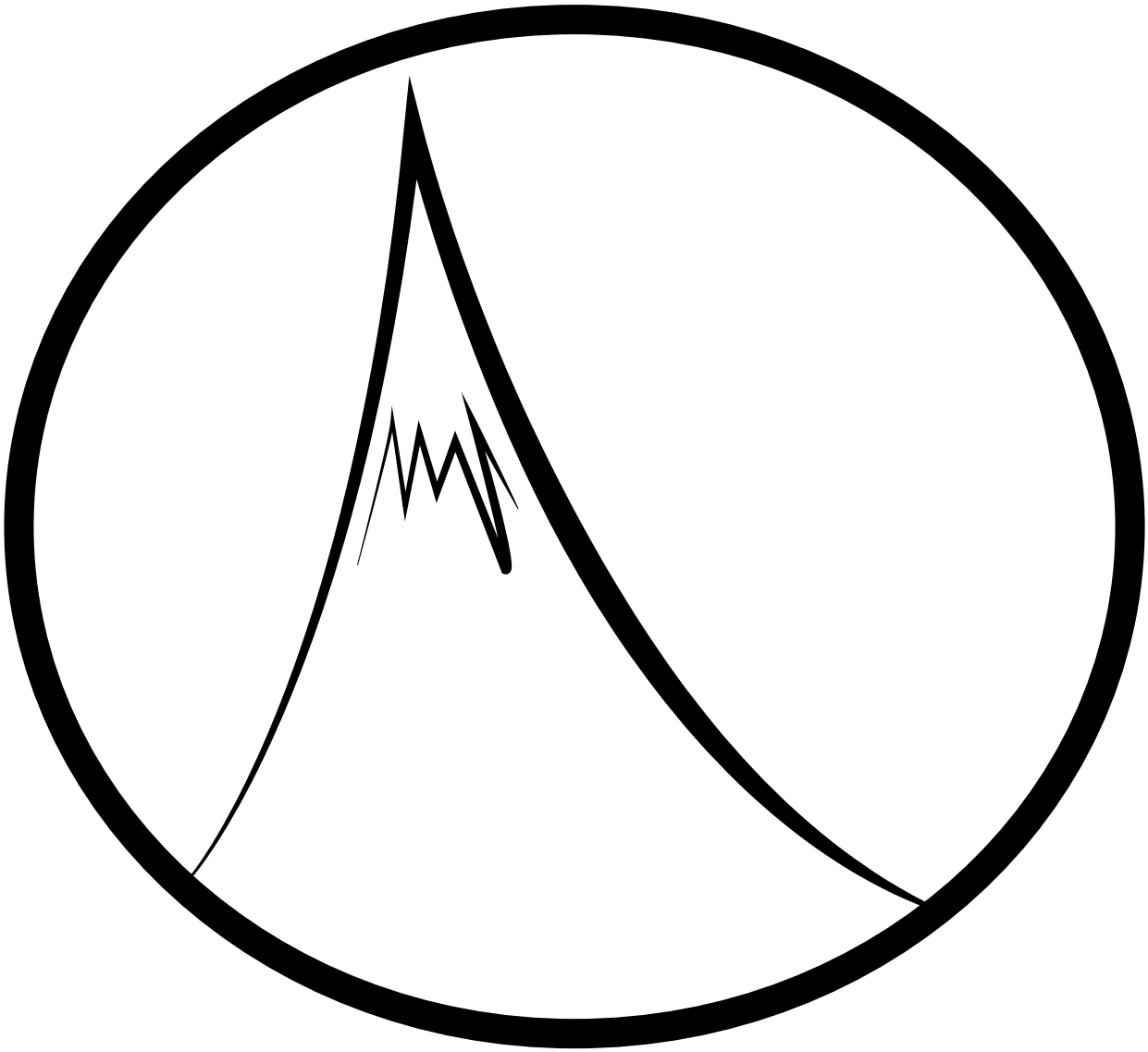
PEAK RESPIRATORY QUESTIONNAIRE
PEDIATRIC

Local and Toll Free Telephone and Fax:

1-855-PFT-PEAK(738-7325)



PEAK MEDICAL SPECIALTY CENTRES

PEAK PULMONARY FUNCTION LABORATORIES

www.peakpulmonary.com

info@peakpulmonary.com

This section to be filled out by clinic staff	
Date:	BMI:
SPO2:	HR:
Ht (cm):	Wt (kg):

PATIENT LABEL OR NAME

PEAK PEDIATRIC RESPIRATORY QUESTIONNAIRE

Symptoms	
1	What best describes what your child's doctor would say about your child's lungs? ☐ Sleep Apnea ☐ Asthma ☐ Cough ☐ Smoker at Risk ☐ Other(please specify):
2	What are your child's main breathing concerns/issues presently (symptoms)?
3	In what year did your child first develop breathing problems? _____

History

1 Does your child have a history of (check all that apply):
☐ Asthma ☐ Chest Illnesses ☐ Sleep Apnea ☐ Heart Disease ☐ High Blood Pressure ☐ Diabetes

2 Is there a family history of lung disease? ☐ Yes (If Yes, check all that apply below) ☐ No (If No, proceed to #3)

Relationship	Asthma	COPD	Chronic Bronchitis	Lung Cancer	Emphysema	Other
Father	☐	☐	☐	☐	☐	☐
Mother	☐	☐	☐	☐	☐	☐
Brother	☐	☐	☐	☐	☐	☐
Sister	☐	☐	☐	☐	☐	☐

3 If your child does have Asthma please answer the following questions:

	Yes	No
a. Does your child cough, wheeze, or have a tight chest because of their asthma (4 or more days a week)?	☐	☐
b. Does your child's coughing, wheezing, or chest tightness wake them at night (1 or more times a week)?	☐	☐
c. Does your child stop exercising because of their asthma (in the past 3 months)?	☐	☐
d. Does your child ever miss school or work because of their asthma (in the past 3 months)?	☐	☐
e. Does your child use their blue inhaler more than 3 times a week (except one dose/day for exercise)?	☐	☐

4 Has your child ever had any of the following (Check all that apply):
☐ Hayfever ☐ Rhinitis ☐ Eczema ☐ Hives ☐ Sinusitis ☐ Nasal Polyps ☐ Allergies ☐ Allergy Testing
☐ Runny Nose ☐ Post Nasal Drip ☐ Nasal Congestion ☐ Sneezing ☐ Itchy, Watery Eyes

5 Which of the following are triggers for your child's asthma or breathing problems? Check all that apply.
Circle all triggers you are uncertain about.

☐ Air Pollution	☐ Cold Air	☐ Grass/Trees/Weeds	☐ Strong Emotions (e.g. hard laugh)
☐ Animals	☐ Damp Places (mould)	☐ Infections/Colds/Viruses	☐ Strong Odours (i.e. paint, perfume)
☐ Aspirin	☐ Dust Mites	☐ Menstrual Cycle (Females)	☐ Weather Changes
☐ Certain Foods	☐ Exercise	☐ Occupational Chemicals	☐ Colds
☐ Cigarette Smoke	☐ Food Additives	☐ Pregnancy (Females)	☐ Other (please specify):

6 Does your child experience heartburn or have gastroesophageal reflux (GERD)? ☐ Yes ☐ No

7 Do you have a pet in the home? ☐ Yes ☐ No If yes, how many and what kind? _____
Does anyone in your home smoke? ☐ Yes ☐ No If yes, who? _____

8 What is your child's occupation or work (if applicable)? _____
Do you find that your child's job, place of employment or school makes their breathing worse?
☐ Yes ☐ No ☐ Don't Know ☐ N/A
If yes, what part (exposures)?

9 Has your child had a flu vaccine? ☐ Yes ☐ No Date of vaccine:

10 How many times in the last 12 months has your child:

	# of Times
a. Been to their doctor/walk-in clinic/emerg dept. for urgent treatment of their breathing or for a chest cold?	_____
b. Been hospitalized for their breathing or for a chest cold?	_____
c. Taken prednisone for treatment of their breathing or for a chest cold?	_____
d. Taken antibiotics for treatment of their breathing or for a chest cold?	_____

11 If your child has a chronic cough, please answer the following questions:
a. Where does their cough originate? ☐ Throat ☐ Chest
b. What time of day does their cough occur? ☐ Morning ☐ Afternoon ☐ Evening ☐ Night
c. Is their cough productive (phlegm)? ☐ Yes ☐ No
d. Do they experience throat clearing? ☐ Yes ☐ No

Smoking

☐ Never Smoked
If your child is a current smoker or has ever smoked before, please answer the following questions.
Smoking includes shisha and the use of e-cigarettes.

	☐ Current Smoker (answer questions below)	☐ Former Smoker (answer questions below)
1		
2	How old were they when they first started smoking? _____	How old were they when they first started smoking? _____
3	Presently how much do they smoke/day? _____ Over the years did they smoke: ☐ Daily, how much a day? _____ ☐ Occasionally, how much a week? _____	Date they quit: _____ Over the years did they smoke: ☐ Daily, how much a day? _____ ☐ Occasionally, how much a week? _____
	Questions 4 to 7 are for Current Smokers only	
4	What medication(s) have they used in the past to try and quit? ☐ Champix ☐ Zyban ☐ Nicotine Patch ☐ Gum ☐ Lozenge ☐ Inhaler ☐ Spray Other (specify):	
5	Would they like to set a quit date? ☐ Yes (quit date: _____) ☐ No	
6	What medication would they like to try for their quit attempt? ☐ Champix ☐ Zyban ☐ Nicotine Patch ☐ Gum ☐ Lozenge ☐ Inhaler ☐ Spray Other (specify):	

SCREENING FOR SLEEP CONCERNS, OBSTRUCTIVE SLEEP APNEA

	While sleeping, do they:	Yes	No	Don't Know
1	Snore more than half the time?	☐	☐	☐
	Always snore?	☐	☐	☐
	Snore loudly?	☐	☐	☐
	Have "heavy" or loud breathing?	☐	☐	☐
	Have trouble breathing, or struggle to breathe?	☐	☐	☐
2	Have you ever noticed that they stop breathing during the night?	☐	☐	☐
3	**Do they:**	**Yes**	**No**	**Don't Know**
	Tend to breathe through the mouth during the day?	☐	☐	☐
	Have a dry mouth on waking up in the morning?	☐	☐	☐
	Occasionally wet the bed?	☐	☐	☐
4	**Do they:**	**Yes**	**No**	**Don't Know**
	Wake up feeling unrefreshed in the morning?	☐	☐	☐
	Have a problem with sleepiness during the day?	☐	☐	☐
5	Has a teacher or other supervisor commented that they appear sleepy during the day?	☐	☐	☐
6	Is it hard for them to wake up in the morning?	☐	☐	☐
7	Do they wake up with headaches in the morning?	☐	☐	☐
8	Did they stop growing at a normal rate at any time since birth?	☐	☐	☐
9	Are they overweight?	☐	☐	☐
10	**Do they:**	**Yes**	**No**	**Don't Know**
	Tend not to listen when spoken to directly?	☐	☐	☐
	Tend to be easily distracted by extraneous stimuli?	☐	☐	☐
	Have difficulty organizing tasks and activities?	☐	☐	☐
	Fidget with their hands or feet or squirm while sitting?	☐	☐	☐
	Find that they are always "on the go" or often act as if "driven by a motor"?	☐	☐	☐
	Tend to interrupt or intrude on others? (e.g. butt into conversations or games)	☐	☐	☐

Daycare (if applicable): _____

I understand that the staff of Peak Pulmonary Consulting Inc. (PPCI) will be performing diagnostic testing on my child as prescribed by their physician. I acknowledge that I have received information about the nature and purpose of the diagnostic testing. I do have the opportunity to ask questions and have those questions answered by the staff of PPCI. The diagnostic testing to be performed is strictly for my child's benefit and will be part of their health records. It will not be used for any research studies, advertising or any other purposes. I understand that this information will be kept confidential and not be for public consumption, and therefore authorize PPCI to collect and use information necessary to provide these diagnostic services. I also authorize PPCI to only refer my child's information to other health care professionals that they designate who require such information to provide additional health services for my child's benefit.

Patient (print): _____ Signature: _____ Date: _____

Parent/Guardian (print): _____ Signature: _____ Date: _____

End of Questionnaire. Thank you!

Medication (this section to be filled out by clinic staff)	
Respiratory Medications (Name/Dose/Frequency)	
ICS/LABA	
ICS	
Short-acting B-agonist	
LTRA	
Nasal Spray/Rinse	
Oral corticosteroids	
Other Medications	

Use of aerochamber: _____

Review of technique: _____

Recommendations & Comments (this section to be filled out by clinic staff)