New Patient Pediatric History Form

Name : Birth Date : / /

1. Medical History

DO YOU HAVE OR HAVE YOU EVER HAD (please check box)

- ☐ **No Known Medical Conditions**
- ☐ Anesthesia Problems (specify ________________________)
- ☐ Bleeding Disorder (specify __________________________)
- ☐ Hearing Loss
- ☐ Ear Infections
- ☐ Ruptured Ear Drum
- ☐ Sinusitis
- ☐ Facial Trauma
- ☐ Tonsillitis (chronic)
- ☐ Heart Disease
- ☐ Hypertension
- ☐ High Cholesterol
- ☐ Arrhythmia
- ☐ Other Cardiac Disorder (specify________________________)
- ☐ Asthma
- ☐ Sleep / Snoring Problems (specify_____________________)
- ☐ Other Lung Disease (specify __________________________)
- ☐ Stomach Ulcers / Colitis
- ☐ GERD (Reflux)
- ☐ Other Stomach Disorder (specify______________________)
- ☐ Acute Renal Failure
- ☐ Kidney Stones
- ☐ Other Renal Disease (specify_________________________)
- ☐ Musculoskeletal Disorder (specify_____________________)
- ☐ Diabetes (specify__________________ controlled ?_______)
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Thyroid Disease (specify____________________________)
- ☐ Other Endocrine Disorder (specify ____________________)
- ☐ Headache /Migraine
- ☐ Seizures (specify___________________________________)
- ☐ Stroke/TIAs (specify________________________________)
- ☐ Other Neurologic Disorder (specify ___________________)
- ☐ Anemia (Iron Deficiency, Hemolytic or Pernicious)
- ☐ Environmental Allergies
- ☐ Chicken Pox
- ☐ Immune Deficiency
- ☐ Other Allergy (specify_______________________________)
- ☐ History of Cancer: Type: ___________________________
  Diagnosed:___________ Treatment:______________
- ☐ Psychiatric Disorder (specify_________________________)
- ☐ Do you have any other disease or condition that you think the doctor should know about?___________________________
  ____

For Women Only

Are you pregnant, or is there any chance that you might be pregnant? ☐Yes ☐ No

Are you nursing? ☐Yes ☐ No

2. Specialists

List any other doctors that you see : ________________________

____

____

____

____

3. Surgical History

- ☐ **No Surgical History**
- ☐ Ear Tubes: when______
- ☐ Septoplasty: when______
- ☐ Tonsils: when_____
- ☐ Sinus Surgery: when______
- ☐ Adenoids: when_____
- ☐ Thyroid (partial, total): when______
- ☐ Cardiac Stent: when________
- ☐ Coronary Artery Bypass: when _______
- ☐ Joint Replacement (specify ____________): when________

Please list any additional operations (and dates) that you have had. ____

____

____

____

4. Family History

- ☐ **No Known Medical Conditions**
- ☐ Anesthesia Problems (specify ________________________)
- ☐ Bleeding Disorder (specify __________________________)
- ☐ Hearing Loss: Relationship:__________________________
- ☐ Sinusitis
- ☐ Heart Disease
- ☐ Hypertension
- ☐ High Cholesterol
- ☐ Other Cardiac Disorder (specify________________________)
- ☐ Asthma
- ☐ Other Lung Disease (specify _______________________)
- ☐ GERD (Reflux)
- ☐ Other Stomach Disorder (specify_____________________)
- ☐ Renal Failure
- ☐ Other Renal Disease (specify_______________________)
- ☐ Rheumatoid Arthritis
- ☐ Lupus
- ☐ Musculoskeletal Disorder (specify____________________)
- ☐ Thyroid Disease (specify___________________________)
- ☐ Other Endocrine Disorder (specify __________________)
- ☐ Headache /Migraine
- ☐ Seizures (specify__________________________________)
- ☐ Stroke/TIAs (specify_______________________________)
- ☐ Vertigo
- ☐ Other Neurologic Disorder (specify __________________)
- ☐ Allergy/Immune/Skin (specify _____________________)
- ☐ Cancer : Type:_________ Relationship:________________
  Type:_________ Relationship:________________
- ☐ Psychiatric Disorder (specify________________________)

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5. Social History - Pediatric

Daycare/School: Name: ______________________
Grade Level: ______________________

Parent's Marital Status: ☐ Married ☐ Separated
☐ Divorced ☐ Unmarried
☐ Lives with ____________

Legal Guardian: Name:________________________
Relation:________________________

Tobacco Exposure: ☐Yes ☐ No
Exposure From:_______________________

Pets: ____

6. Prior Testing

☐ Allergy Testing: Skin or Blood Test? When____________
Sensitivities: _______________________________
Immunotherapy: When_______ Duration_______

☐ CT Scan of the Sinuses or Neck
When_______ Where_________

☐ MRI of the Brain or Neck When_______ Where_________

☐ Swallow Study When_______ Where_________

☐ Ultrasound of the Neck When_______ Where_________

7. Current Symptoms

What is your main symptom? __________________________
When did this symptom start?__________________________
How Frequent?___________ Rate the Severity (1-10)________
Quality (eg. pain, pressure, shooting)_____________________

8. Review of Systems

PLEASE NOTE ANY CURRENT SYMPTOMS BELOW
(please check box)

Ear
- ☐ Ear Pain R - L - Both
- ☐ Hearing Loss R - L - Both
- ☐ Ear Drainage R - L - Both
- ☐ Noises in Ear R - L - Both

Nose
- ☐ Nasal Obstruction
- ☐ Sinus Pressure or Pain
- ☐ Abnormal Sense of Smell
- ☐ Runny Nose

Throat
- ☐ Sore Throat
- ☐ Hoarseness
- ☐ Snoring/Sleep Apnea
- ☐ Throat Clearing
- ☐ Swallowing Problems

Eyes
- ☐ Eye Pain
- ☐ Itching or Watery Eyes

Heart / Chest
- ☐ Chest Pain
- ☐ Dizziness
- ☐ Palpitations

Lungs / Respiratory
- ☐ Cough
- ☐ Shortness of Breath
- ☐ Coughing up Blood
- ☐ Wheezing

Stomach / Gastrointestinal
- ☐ Heartburn / Reflux
- ☐ Stomach Pain

Urinary
- ☐ Painful Urination
- ☐ Frequent Urination

Musculoskeletal
- ☐ Joint Pain/Aches
- ☐ Muscle Pain/Aches

Skin
- ☐ Itching
- ☐ Rash
- ☐ Hives

Neurology
- ☐ Headaches
- ☐ Fainting

Blood / Glands
- ☐ Easy Bruising
- ☐ Bleeding Problems
- ☐ Swollen Glands

Endocrine
- ☐ Heat / Cold Intolerance
- ☐ Sweating at Night

Psychiatric
- ☐ Anxiety or Panic
- ☐ Depression

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Medication List

Please include supplements and over-the-counter medications

Medication:	Dose:	Frequency:

Medication Allergies

Medication:	Reaction: *(Rash, vomiting, difficulty breathing ,etc.)*

Pharmacy:

Name:________________________

Address/Location:_______________

____

Phone:________________________