

Please answer this questionnaire to the best of your knowledge. Information is confidential and will be used by the care providers of The Ear, Nose and Throat Clinic & Hearing Center to evaluate and treat your medical problems.

THE EAR, NOSE AND THROAT CLINIC
& HEARING CENTER

Pediatric Medical History Form

Please print (if you do not understand a question, leave it blank)

Today's date _____

PATIENT NAME _____
(First) (M) (Last) (Date of birth)

Name of your child's pediatrician or family doctor: _____ Clinic: _____

Is your child in good health? No ___ Yes ___ If no, please explain: _____

Does your child have any current or past medical problems? (e.g. heart, lung, urinary tract, blood, immune system, etc.) No ___ Yes ___

If yes, please explain: _____

Does your child have a specific named syndrome? No ___ Yes ___ If yes, please list: _____

Was there a problem during your child's pregnancy, labor and/or delivery? No ___ Yes ___ If yes, please explain: _____

Child's height: _____ Child's weight: _____

Previous hospitalization(s)? No ___ Yes ___ If yes, please list: _____

Previous surgery? No ___ Yes ___ If yes, please list: _____

Current medications: No ___ Yes ___ Please list: _____

Allergies: Medications? No ___ Yes ___ Please list: _____

Hay fever, dust, etc.? No ___ Yes ___ Please list: _____

Foods? No ___ Yes ___ Please list: _____

Does your child have problems with excessive bleeding or easy bruising? No ___ Yes ___ If yes, please explain: _____

Is there a family history of unusual or severe diseases or bleeding problems? No ___ Yes ___ If yes, please explain: _____

Is your child in daycare? No ___ Yes ___ If yes, your child is in day care with (please check one) More than 10 children Less than 10 children

Are there any pets in the home? No ___ Yes ___ Please list: _____ Are there any smokers in the home? No ___ Yes ___

If the child is over 13 years-old, do they use tobacco? Yes ___ No ___ (Cigarettes ___ Chewing ___ Cigar/Pipe ___ Cessation in progress ___)

Is there any other information you would like to share about your child? No ___ Yes ___ If yes, please explain: _____

Physician use only: Date/Initials _____