

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: \_\_\_\_\_

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

Physician use only: Date/Initials \_\_\_\_\_