MT SCOTT
EAR, NOSE AND THROAT, & SLEEP MEDICINE

Pediatric Health History Form

Name:_____Age:_____DOB:_____Date:_____

Referring Physician:_____ Primary Physician:_____

Main reason for today's visit:_____
_____

Personal Medical History: Please indicate if your child has any of the following.

□ Heart Problems □ Pneumonia □Kidney Problems
Please Explain:_____ □ Diabetes □ Bleeding Disorder
□ Asthma/Lung Problems □ Other (Specify):_____

Was there a problem with your pregnancy, labor or delivery? Yes/No_____

Surgical History/Prior Hospitalizations: Please list all prior surgeries and hospitalizations with dates.

Procedure:	Reason/Date:	Procedure:	Reason/Date:
_____		_____	
_____		_____	

Medications: Current prescription and non=prescription medications, vitamins, herbals, supplements, ect.

Medication:	Dose:	Medication:	Dose:
_____		_____	
_____		_____	

Allergies: Please list all allergies to medications and the reaction.

Allergic to:	Reaction:	Allergic to:	Reaction:
_____		_____	
_____		_____	

Has your child in the past year or currently have any of the following?

□ Hearing Loss
□ Frequent ear infections
If yes how often?_____
How were they treated?_____
□ Frequent runny nose
□ Chronic nasal congestion
□ Nosebleeds
□ Frequent sore throats
□ Snoring
□ Period where child stops breathing during sleep
□ Fevers
□Discharge/Drainage from ears
□ Earaches
□ Failed hearing tests
□ Delayed speech
□ Headaches
□ Sinus problems
□ Allergies/Hay fever
If yes, to what?_____
□ History of strep throat
□ Chronic cough

Social History:

Does the child attend daycare: Yes / No
Is the child around anyone who smokes? Yes / No
Are there pets in the house? Yes / No If yes, type:_____
Child's grade in school:_____
Did the child reach developmental milestones (walking, talking, ect)? Yes / No

Family History: Indicate family members (parent, sibling, grandparent) who has the following.

□ Heart Disease	□ High Blood Pressure	□ Thyroid problem
□ Stroke	□ Diabetes	□ Headaches
□ Asthma/Lung disease	□ Sleep Apnea	□ Bleeding disorder
□ Cancer (Specify):_____	□ Hearing Loss	□ Problem w/ Anesthesia

Review of Systems: Does your child have problems with any of the following?

General Health:	□ No □ Fever □Unintentional weight loss □ Fatigue
Cardiovascular:	□ No □ Irregular heart beat □ Murmur
Lungs:	□ No □ Chronic cough □ Wheezing □ Shortness of breath
Gastrointestinal:	□ No □ Heartburn □ Abdominal pain □ Nausea □Vomiting □ Diarrhea
Genitourinary:	□ No □ Wetting the bed
Musculoskeletal:	□ No □ Muscle pain □ Joint pain
Neurological:	□ No □ Headaches □ Delayed speech
Psychiatric:	□ No □ Difficulty concentrating □ Behavior problems □Depression □ Mood swings
Blood/Lymph:	□ No □ Slow to heal after cuts □ Bruises easily □ Bleeds excessively □ Unexplained lumps
Skin:	□ No □ Rash □ Hives

Other:
Is there any other information about your child you would like to share?

-
_____
_____
_____
_____
_____

Signature:_____Date:_____

Relationship to Patient:_____