MT SCOTT
EAR, NOSE AND THROAT, & SLEEP MEDICINE

Pediatric Health History Form (Age 12 and under)

Name: _____Age:_____DOB:_____Date:_____

Referring Physician: _____ Primary Physician: _____

Main reason for today's visit: _____

Preferred pharmacy name & location: _____

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

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

Were there any problems 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, etc.

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

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

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

Family History: Please indicate if family members (parents, siblings, grandparents, aunts or uncles) have a history of the following:

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

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 current grade in school: _____

Did the child reach developmental milestones (walking, talking, etc.)? Yes / No

Review of Systems:

Please indicate if your child currently has, or has had within the past year, any of the following:

General Health: □ Fatigue □ Fever □ Significant weight loss
Sleep Health: □ Snoring □ Apnea (child stops breathing while sleeping) □ Insomnia □ Waking up tired □ Daytime Tiredness
Eye/Ear Health: □ Itchy Eyes □ Watery Eyes □ Hearing Loss □ Ear pain □ Ear drainage
Nose: □ Frequent runny nose □ Chronic nasal congestion □ Nosebleeds □ Sneezing
Mouth/Throat: □ Frequent sore throat □ Voice changes □ Problems swallowing □ Mouth sores
Neck: □ Swollen glands □ Neck lumps
Cardiovascular: □ Irregular heart beat □ History of heart murmur
Lungs: □ Chronic cough □ Wheezing □ Shortness of breath
Gastrointestinal: □ Heartburn □ Abdominal pain □ Nausea □Vomiting □ Diarrhea
Genitourinary: □ Wets the bed
Musculoskeletal: □ Muscle pain □ Joint pain
Neurological: □ Headaches □ Delayed speech
Psychiatric: □ Difficulty concentrating □ Behavior problems □ Depression □ Mood swings
Blood/Lymph: □ Slow to heal after cuts □ Bruises easily □ Bleeds excessively □ Unexplained lumps
Skin: □ Rash □ Hives

Does your child experience frequent ear infections? Yes / No If yes, how often? _____

How have they been treated in the past? _____

Does your child have a history of strep throat? Yes / No If yes, how often? _____

Does your child have allergies/hay fever? Yes / No

Other:

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

_____

_____

Signature: _____Date:_____

Relationship to Patient: _____