MT SCOTT
EAR, NOSE AND THROAT, & SLEEP MEDICINE

Pediatric Health History Form (Age 12 and under)

Name: _____ Age: _____ DOB: _____ Date: _____

Referring Physician: _____ Primary Physician: _____

Reason for visit: _____

Preferred pharmacy name & location: _____

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

□ Heart Problems Please Explain: _____

□ Pneumonia □ Kidney Problems □ Diabetes □ Bleeding Disorder □ Asthma/Lung Problems

□ Other (Please specify):_____

Were there any problems with your pregnancy, labor or delivery? Yes/No_____

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

Procedure: Reason/Date: 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: Allergic to: Reaction:

_____ _____ _____

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

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: _____ Current grade in school: _____

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

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

Signature: _____ **Relation:** _____ **Date:** _____