advanced
EAR, NOSE & THROAT
head and neck surgery

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Pediatric History

Please answer each question by filling in the appropriate circle fully.

Patient accompanied by: O mother O father O care provider

Is the patient over the age of 18? O Yes O No

Is the patient accompanied by guardian? O Yes O No

Does the patient have any medical problems?

- O ADHD
- O Anemia
- O Asthma
- O Other lung problems
- O Anxiety/Depression
- O Developmental delay
- O Diabetes
- O Dizziness
- O Down's syndrome
- O Heart murmur
- O Irregular heartbeat
- O Migraine headache
- O Mitral valve prolapse
- O Vision problems
- O Sinusitis
- O Allergies
- O Genitourinary problems
- O Seizures
- O Thyroid problems
- O Blood cancer
- O Skin problems
- O Other, please list:_____
- O None

Please List all Medications that you are currently taking:_____
_____

Please List all Allergies to Medications and the reaction you have to them:_____

Please List all Surgeries:_____

Pediatric History

Please answer each question by filling in the appropriate circle fully.

Did patient's mother receive prenatal care? O Yes O No

Did patient's mother have or use any of the following during pregnancy?

O Infection O High Blood pressure O Diabetes
O Alcohol O tobacco O Drugs

Was baby born within 2 weeks of due date? O Yes O No

Did patient have any complications during newborn nursery stay?

O No
O breathing problems
O Jaundice requiring treatment
O Infection
O Birth injury
O Birth defect

Does anyone in the family: (brothers, sisters, Father, Mother) have...?

O ear problems O hearing loss O head and neck cancers
O allergies O sinus problems O other:_____

Does the Patient…?

Smoke	O Yes O No
Have Second hand smoke exposure	O Yes O No
Drink Alcohol	O Yes O No
Use Smokeless Tobacco	O Yes O No
Use Recreational drug	O Yes O No
Drink Caffeine:	O Yes O No
Attend Daycare:	O Yes O No
Have Pets:	O Yes O No

Pediatric History

Please answer each question by filling in the appropriate circle fully.

Has the patient experienced any of the following in the last 6 months?

fever	O Yes	O No
chills	O Yes	O No
weight change	O Yes	O No
loss of appetite	O Yes	O No
hearing loss	O Yes	O No
sore throat	O Yes	O No
epistaxis	O Yes	O No
change in voice	O Yes	O No
ringing in ears	O Yes	O No
dizziness	O Yes	O No
used Q-tips	O Yes	O No
allergies	O Yes	O No
ear pain	O Yes	O No
ear drainage	O Yes	O No
ear fullness	O Yes	O No
high blood pressure	O Yes	O No
irregular heart rhythm	O Yes	O No
murmur	O Yes	O No
nausea	O Yes	O No
vomiting	O Yes	O No
diarrhea	O Yes	O No
heartburn	O Yes	O No
rash	O Yes	O No
hives	O Yes	O No
itching	O Yes	O No
diabetes	O Yes	O No
thyroid disease	O Yes	O No

Pediatric History

Please answer each question by filling in the appropriate circle fully.

Has the patient experienced any of the following in the last 6 months?

headache	O Yes O No
tingling or numbness	O Yes O No
memory loss	O Yes O No
blurring of vision	O Yes O No
asthma	O Yes O No
cough	O Yes O No
wheezing	O Yes O No
sinus congestion	O Yes O No
stuffy nose	O Yes O No
runny nose	O Yes O No
scratchy throat	O Yes O No
itchy eyes	O Yes O No
easy bruising	O Yes O No
anemia	O Yes O No
visual changes	O Yes O No
arthritis	O Yes O No
muscle aches	O Yes O No
rheumatoid arthritis	O Yes O No