Pediatric Patient History

(To provide you with the best possible care, please complete all sections below. This will give us a full medical and family history. All answers will remain CONFIDENTIAL.)

Name _____ Age _____ Date _____

Referred by _____ Family Physician _____

Family Physician's or Patient's Hospital Choice:

❑ Hamot ❑ Saint Vincent ❑ Millcreek ❑ Metro ❑ Other _____

Sex: ❑ Male ❑ Female

Patient History of Present Illness

What problem(s) brought you here today? _____

_____

_____

_____

Have you had this problem before? ❑ Yes ❑ No

If yes, when did you first experience it and how long did it last? _____

_____

_____

Have you had any recent: ❑ Lab Work ❑ Culture ❑ X-Ray ❑ CT Scan ❑ MRI Scan ❑ Hearing Tests

Please specify: _____

_____

_____

Please list past or current treatment, surgery or medications for this problem: _____

_____

_____

_____

Social History

Smoking — Does patient have exposure at home to smoke? ❑ Yes ❑ No

Daycare — Is patient in daycare? ❑ Yes ❑ No

School Grade Level _____

Patient's Review of Symptoms

*Please check Yes or No if you **currently** have the following:*

Name _____ Chart No. _____

Face/Neck:

❑ Yes ❑ No Pain in neck or face
❑ Yes ❑ No Lump/mass in neck or face

Ears:

❑ Yes ❑ No Hearing loss ❑ Right ❑ Left
❑ Yes ❑ No Earache ❑ Right ❑ Left
❑ Yes ❑ No Ear Drainage ❑ Right ❑ Left
❑ Yes ❑ No Itchy ears ❑ Right ❑ Left

Number of ear infections in past 12 mo.?_____

Nose:

❑ Yes ❑ No Breathing obstruction ❑ Right ❑ Left
❑ Yes ❑ No Nosebleeds ❑ Right ❑ Left
❑ Yes ❑ No Congestion or stuffiness
❑ Yes ❑ No Runny nose: ❑ watery ❑ thick
❑ Yes ❑ No Pain or discomfort in nose or sinuses
❑ Yes ❑ No Seasonal problems with nose/sinuses
❑ Spring ❑ Summer ❑ Fall ❑ Winter
❑ Yes ❑ No Nighttime snoring
❑ Yes ❑ No Nighttime mouth breathing

Throat/Mouth:

❑ Yes ❑ No Sore throat/pain
❑ Yes ❑ No Tickle, clearing
❑ Yes ❑ No Hoarseness or voice change
❑ Yes ❑ No Pain near ❑ teeth ❑ gums ❑ mouth

Number of throat infection/tonsillitis in past 12 mo.?_____

Respiratory:

❑ Yes ❑ No Cough
❑ Yes ❑ No Wheezing
❑ Yes ❑ No Shortness of breath

Gastrointestinal:

❑ Yes ❑ No Heartburn/acid reflux/indigestion
❑ Yes ❑ No Nausea or vomiting
❑ Yes ❑ No Diarrhea

General:

❑ Yes ❑ No Weakness or fatigue
❑ Yes ❑ No Recent weight loss;
How much? _____

Eyes:

❑ Yes ❑ No Blurred vision
❑ Yes ❑ No Double vision
❑ Yes ❑ No ❑ Eye redness ❑ itchiness ❑ burning

Neurological:

❑ Yes ❑ No Numbness in face, legs, arms, etc.
❑ Yes ❑ No Weakness of arms or legs
❑ Yes ❑ No Difficulty speaking
❑ Yes ❑ No Confusion or memory loss
❑ Yes ❑ No Dizziness

Hematologic/Lymphatic:

❑ Yes ❑ No Easy bruising or bleeding
❑ Personal ❑ Family

Genitourinary:

❑ Yes ❑ No Problems urinating
❑ Yes ❑ No Blood in urine

Musculoskeletal:

❑ Yes ❑ No Joint pain or stiffness
❑ Yes ❑ No Deformity

Skin/Hair/Nails:

❑ Yes ❑ No Rashes/hives
❑ Yes ❑ No Skin lesions

Headache: ❑ Yes ❑ No

❑ Yes ❑ No Constant
❑ Yes ❑ No Periodic
❑ Yes ❑ No Throbbing
❑ Yes ❑ No Pressure
❑ Yes ❑ No Nausea
❑ Yes ❑ No Eye symptoms
❑ Yes ❑ No Sensitivity to light
❑ Yes ❑ No Responds to medication (list):

_____

_____

_____

_____

_____

Where is it located?_____

_____

_____

Positive review of systems responses not related to ENT have been discussed with patient.
The patient has been advised to see their PCP.

_____
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Patient and Family Medical History

Have you or anyone in your family **(parents, grandparents, brother, sister)** been diagnosed or had problems with any of the following:

	Self	Family	Who	Comments
Allergies	❑ Yes ❑ No	❑ Yes ❑ No		
Arthritis or Gout	❑ Yes ❑ No	❑ Yes ❑ No		
Blood Diseases	❑ Yes ❑ No	❑ Yes ❑ No		
Bladder or Prostate	❑ Yes ❑ No	❑ Yes ❑ No		
Breast Lump/Cyst	❑ Yes ❑ No	❑ Yes ❑ No		
Cancer	❑ Yes ❑ No	❑ Yes ❑ No		
Diabetes	❑ Yes ❑ No	❑ Yes ❑ No		
Eyes/Vision	❑ Yes ❑ No	❑ Yes ❑ No		
Hearing	❑ Yes ❑ No	❑ Yes ❑ No		
Heart Disease	❑ Yes ❑ No	❑ Yes ❑ No		
Heart Murmur	❑ Yes ❑ No	❑ Yes ❑ No		
High Blood Pressure	❑ Yes ❑ No	❑ Yes ❑ No		
Jaundice (Hepatitis)	❑ Yes ❑ No	❑ Yes ❑ No		
Kidney Diseases	❑ Yes ❑ No	❑ Yes ❑ No		
Mental Illness	❑ Yes ❑ No	❑ Yes ❑ No		
Seizures	❑ Yes ❑ No	❑ Yes ❑ No		
Stomach or Bowel	❑ Yes ❑ No	❑ Yes ❑ No		
Stroke	❑ Yes ❑ No	❑ Yes ❑ No		
Tuberculosis	❑ Yes ❑ No	❑ Yes ❑ No		
Anesthesia Reaction	❑ Yes ❑ No	❑ Yes ❑ No		
Asthma	❑ Yes ❑ No	❑ Yes ❑ No		
Thyroid Problems	❑ Yes ❑ No	❑ Yes ❑ No		
Other _____	❑ Yes ❑ No	❑ Yes ❑ No		

Hospitalizations, Operations, Injuries

Date	Hospital	Illness/Surgery/Injury	Complications

Allergies (Food and Drug) and reaction: _____

_____

Other doctors you are currently seeing: _____

_____

I Certify that all the information listed above on these sheets is, to the best of my knowledge, true and correct.

_____ Patient's Signature (Parent/Guardian if patient is a minor)

_____ Date

_____ Nurse's Signature

_____ Date

Reviewed & confirmed by _____ Physician/P.A. _____ Date

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