



ENT Associates

CHILD HISTORY

DATE _____

Name _____ Age _____

Pediatric Doctor _____ Referring Doctor _____

Reason for Visit: _____

Past Medical History:(please check) Asthma: Yes No Ear Infections: Yes No

Tonsillitis: Yes No Heart Murmur: Yes No Premature Birth: Yes No

Current Medication (please list) _____

Drug Allergies (please list) _____

Environmental Allergies Yes No

Previous Surgery (please list) _____

Birth History: Was child born full term? Yes No Normal Vaginal Delivery? Yes No

C-Section? Yes No Was child healthy at birth? Yes No

Please list any problems during pregnancy _____

Please list any problems at birth _____

Social History:

Does child live with Mother____ Father____ Grandparents____ Other____ How many siblings _____

Any medical problems with siblings? (please list) _____

Are there pets in your home? (please list) _____

Is child in day-care? Yes No Is child in school? Yes No What grade? _____

How is child performing in school? _____

Does anyone smoke in the family? Yes No Does anyone smoke inside the home? Yes No

Family History: Has anyone in family had:

Diabetes (Sugar) Yes No Hearing Loss Yes No Cancer Yes No

Migraine Headache Yes No Bleeding Problems Yes No Heart Disease Yes No

High Blood Pressure Yes No Asthma Yes No Psychiatric Problems Yes No

Ear Infections Yes No Sleep Apnea Yes No Other? _____

Review of Systems: Please indicate yes or no if the child has, or has had, any of the following:

ADHD Yes No Growth Delay Yes No Rubella Yes No

AIDS Yes No Hearing Problems Yes No Sinusitis Yes No

Attention Deficit Yes No Hyperactivity Yes No Sleep Apnea Yes No

Anemia Yes No Heart Disease Yes No Snoring Yes No

Asthma Yes No Heart Murmur Yes No Speech Delay Yes No

Birth Defects Yes No Hepatitis Yes No Suicide Attempt Yes No

Bleeding Problems Yes No Herpes Yes No Thyroid Problems Yes No

Bronchitis Yes No HIV Positive Yes No Tinnitus - Ears Ringing Yes No

Chicken Pox Yes No Kidney Disease Yes No Tonsillitis Yes No

Cough Yes No Liver Disease Yes No Cancer Yes No

Diabetes (sugar) Yes No Measles Yes No Allergy Shots Yes No

Dizzy - Balance Problem Yes No Mentally Challenged Yes No Allergies Yes No

Down's Syndrome Yes No Mononucleosis Yes No Other? _____

Ear Infections Yes No Migraine Headache Yes No _____

Epilepsy Yes No Psychiatric Problem Yes No _____

Fibromyalgia Yes No Acid Reflux Disease Yes No _____