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	_____	