LAKE GROVE ENT

EAR NOSE & THROAT

Pediatric Health History Doctor you are seeing today (Circle one): Yang, Schettler-Huberty, Furman, Desai, March

Today's date: _____ Referring Provider: _____

Patient Name: _____

Date of birth: _____ Age: _____ Gender: _____

Weight: _____ Height: _____

What is the primary reason for your child's visit with the doctor today?

_____

	Yes	No
LATEX ALLERGY	□	□
DRUG ALLERGIES	□	□

Please list medications and reactions:

_____

Medications

Please list any medications that your child takes on a regular basis. Include medication name, dose, and frequency.

_____

Past Medical History

	Yes	No
Does your child have any diagnosed medical problems?	□	□

Please list:

_____

	Yes	No
Has your child ever had cancer?	□	□

If so, what type?

_____

	Yes	No
Has your child ever had surgery?	□	□

Please list type and approximate date:

_____

Social History for Children:

Who is the primary caregiver of your child (mother, father, grandparent, etc.)?

_____

	Yes	No
Does your child attend daycare?	□	□
Does anyone smoke around your child?	□	□
Has your child been immunized	□	□
If yes, are the immunizations current?	□	□
Does your child have siblings?	□	□

If yes, please list ages and any diagnosed medical problems:

_____

Family History:

Any family history of the following?	Yes	No	If answered yes, please list family member(s) relation to your child:
Heart Disease	□	□	_____
Arthritis	□	□	_____
Cancer	□	□	_____
Diabetes	□	□	_____
Bleeding tendencies	□	□	_____
Other: _____			_____

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Does your child have any of the following:	Yes	No
Trouble sleeping	□	□
Frequent awakening	□	□
Snoring	□	□
Mouth breathing	□	□
Restless legs	□	□
Restless sleep	□	□
Sleep walking	□	□
Sleep talking	□	□
Wetting the bed	□	□
Trouble eating	□	□
Finicky eater	□	□

	Yes	No
Frequent sinus infections		
If yes, how many per year? _____		
Frequent tonsil infections		
If yes, how many per year? _____		
Frequent ear infections		
If yes, how many per year? _____		
Trouble hearing		
If yes, for how long? _____		
Speech difficulty	□	□
Reflux	□	□
Large tonsils	□	□

Review of Systems

Do you currently have any of the following symptoms?

	Yes	No
Constitutional Systems		
Fever	□	□
Chills	□	□
Fatigue	□	□
Unexpected Weight loss	□	□
Eyes		
Itchy Eyes	□	□
Visual disturbances	□	□
Light sensitivity	□	□
Excessive thirst	□	□
Respiratory		
Wheezing	□	□
Frequent cough	□	□
Shortness of breath	□	□
Apnea	□	□
Cardiovascular		
Chest pain	□	□
Chest tightness	□	□
Heart attack	□	□
Gastrointestinal		
Abdominal pain	□	□
Nausea/vomiting	□	□
Voice hoarseness	□	□
Trouble swallowing	□	□

	Yes	No
Neurological		
Dizziness	□	□
Headaches	□	□
Ringing in ears	□	□
Hearing loss	□	□
Ear Pain	□	□
Endocrine		
Excessive thirst	□	□
Hot/cold Intolerance	□	□
Hematological/Lymphatic		
Easy bruising/Bleeds easily	□	□
Swollen lymph nodes	□	□
Nosebleeds	□	□
Allergy/Immunologic		
Runny nose	□	□
Post nasal drip	□	□
Congestion	□	□
Pets in the home	□	□
Immunocompromised	□	□

Preferred Pharmacy: _____

Location: _____

Please return the completed form to the front desk
Thank you!