Lakeshore
EAR, NOSE, THROAT CENTER, PC

PEDIATRIC HEALTH HISTORY

Today's Date: _____/_____/_____
Child's Name: _____ Date of Birth: _____/_____/_____
Child's Height: _____ Child's Weight: _____
Parent/Guardian Name: _____ Relationship: _____
Preferred Phone Number: (_____)_____ Email: _____
Pediatrician: _____
Did a physician refer you to Lakeshore ENT? ☒Yes ☐ No If "Yes," which physician: _____
Where does your child's pediatrician send him/her for testing? _____
How did you hear about us if you were not referred by a physician? ☐ Family ☐ Friend ☐ Internet ☐Other
Preferred Pharmacy (name and phone number): _____

REASON FOR VISIT: *(please answer all questions that apply)*

What is the reason for your child's visit today? _____
When did this problem/pain start? _____
Where is problem/pain located? _____
What makes problem/pain worse? _____
What makes problem/pain better? _____
What is severity of problem/pain? (*circle one*) 0 (none) 1 2 3 4 (moderate) 5 6 7 8 9 10 (severe)

What medications/treatments has your child tried for this problem? _____

_____

If there are other symptoms associated with this problem/pain, please describe: _____

_____

SURGERIES and HOSPITALIZATIONS: *(please list all below)*

Type of Surgery/Reason for Hospitalization	Date	Post-Surgical Problems (if any)
1.		
2.		
3.		
4.		

MEDICATIONS:

Medication list attached: ☐Yes ☐ No If "No," list all medications your child is taking including dose and frequency:

_____

_____

List any medications your child is allergic to including reactions they caused: _____

_____

Are your child's immunizations up to date? ☐Yes ☐ No

CHILD'S MEDICAL HISTORY: *(please check all that apply)*

☐Allergies (food)	☐Cleft Lip/ Palate	☐Headaches/ Migraines	☐Kidney/Renal Disease
☐Allergies (seasonal)	☐Cough/Croup	☐Hearing Loss	☐Meningitis
☐Arthritis	☐Developmental Delay	☐Heart Disorder	☐Reflux (GERD)
☐Asthma	☐Diabetes	☐Hemangioma	☐Seizures
☐Bleeding Disorders	☐Ear Infections	☐HIV/AIDS/Hepatitis	☐Speech Delay
☐Other (please describe):			

(PLEASE COMPLETE THE NEXT PAGE OF THIS FORM)

Child's Name: _____

Date of Birth: _____/_____/_____

FAMILY MEDICAL HISTORY: *(please check all that apply and note relationship)*

☐Allergic Rhinitis	☐Cancer	☐Malignant Hyperthermia
☐Anesthesia Problems	☐Diabetes	☐Migraines
☐Asthma	☐Early Hearing Loss	☐Vertigo
☐Bleeding Disorders	☐Hypertension	

SOCIAL HISTORY:

Does your child have siblings? ☐Yes ☐No If "yes" list names and ages:	
Does anyone smoke at home? ☐Yes ☐No	Are there any animals or pets at home? ☐Yes ☐No
Does your child attend a daycare or preschool? ☐Yes ☐No If "yes" how many days/week?	
Does your child have special religious, spiritual, or cultural needs that we should to be aware of? ☐Yes ☐No If yes, please explain:	

PRE/ PERINATAL HISTORY:

# of weeks your child was at delivery:	Birth weight:
Apgar score *(if known)*: at 1 min. / at 5 min.	
Any breathing problems at birth? ☐Yes ☐No	Any jaundice requiring treatment? ☐Yes ☐No
Did your child pass their newborn hearing screening? ☐Yes ☐No ☐ Don't know	
Any significant illness during pregnancy? ☐Yes ☐No If "yes" please explain:	

REVIEW OF SYSTEMS: *(please check all that apply)*

Constitutional: ☐fatigue ☐fever ☐weight loss (_____lbs) ☐weight gain (_____lbs)
Eyes: ☐blurred vision ☐double vision ☐itching ☐burning ☐eye pain
Ears: ☐difficulty hearing ☐ear pain ☐vertigo ☐tinnitus (ringing) ☐ears feel pressured ☐discharge from ears
Nose: ☐frequent nosebleeds ☐nasal congestion ☐nose/sinus problems ☐rhinorrhea (nasal mucus) ☐sinus pressure ☐blockage/obstruction
Mouth/Throat: ☐sore throat ☐bleeding gums ☐snoring ☐dry mouth ☐oral abnormalities ☐mouth ulcer ☐teeth abnormalities ☐difficulty swallowing ☐post nasal drip ☐hoarseness ☐mouth breathing
Neurologic: ☐fainting ☐frequent headaches ☐seizures ☐numbness ☐weakness ☐migraines ☐restless legs
Cardiovascular: ☐chest pain ☐history of heart murmur ☐dyspnea on exertion ☐palpitations ☐edema ☐light-headed on standing
Respiratory: ☐wheezing ☐shortness of breath ☐hemoptysis ☐sputum production ☐sleep apnea ☐cough
Genitourinary: ☐difficulty urinating ☐pain during urination ☐urinary retention
Gastrointestinal: ☐vomiting ☐heartburn ☐painful swallowing ☐no appetite ☐increased appetite
Hematologic/Lymphatic: ☐swollen glands ☐easy bruising ☐excessive bleeding
Psychiatric: ☐depression ☐anxiety ☐restless sleep
Musculoskeletal: ☐muscle aches ☐joint pain/arthralgia
Skin: ☐rash ☐itching ☐dry skin ☐growths/lesions
Endocrine: ☐increased thirst ☐increased drinking ☐increased hunger
Allergy/Immunologic: ☐frequent sneezing ☐runny nose

Please list any other problems or concerns you think the physician should be aware of: _____

_____

_____

Patient/Guardian Signature: _____