



Name _____
 Date of Birth _____

Family Physician _____
 Today's Date _____

Current Medications _____

Drug Allergies _____
 Non Drug Allergies _____

As Needed Medications _____
 (OTC and vitamins included) _____

Birth Hospital _____
 Born Full Term Yes/No
 NICU stay Yes/No

Preferred Pharmacy: _____

Height: _____ Weight: _____

Ear History

Newborn Hearing Screening Pass/Fail
 School/AEA/Pediatrician Hearing Screening Pass/Fail
 Ear Infections Yes/No
 age of onset _____
 how often _____
 medications used _____
 Previous Ear Surgery Yes/No
 Concern for Hearing Loss Yes/No
 Concern for Speech Delay Yes/No
 Family History of Early Onset Hearing Loss Yes/No
 if yes, please explain _____

Nasal/Sinus History

Congestion Yes/No
 Nasal Drainage Yes/No
 Chronic Cough Yes/No
 if yes, more often during Day/Night
 Headaches Yes/No
 Seasonal Allergies Yes/No
 allergy testing Yes/No
 family history of seasonal allergies Yes/No
 Eczema Yes/No
 Nosebleeds Yes/No
 if yes, how frequent _____

Oral/Throat History

Recurrent infections/sore throats Yes/No
 strep swab positive Yes/No
 Snoring Yes/No
 Episodes of paused breathing during sleep Yes/No
 if yes, what is the duration _____
 Restless sleeper Yes/No
 Difficulty swallowing food Yes/No
 picky eater Yes/No
 Bad Breath Yes/No

Airway History

Reactive airway disease/asthma Yes/No
 Describe symptoms _____
 is it improving with time? Yes/No
 is it worse with feeding? Yes/No
 is child gaining weight? Yes/No
 Previous Chest Xray Yes/No
 Previous Swallow Study Yes/No
 Hospitalizations Yes/No
 ER Visits Yes/No

General History

Previous Surgeries

Previous Hospitalizations

Gastrointestinal Problems

Yes/No

Immune/Endocrine Problems

Fevers/Chills/Weight Loss

Yes/No

abnormal immune studies

Yes/No

Kidney Problems

Yes/No

sweat chloride test

Yes/No

Neurological Problems

HIV/HEP/TB

Yes/No

balance issues

Yes/No

family history of immune disorders

Yes/No

head injury

Yes/No

BLEEDING

seizures

Yes/No

history of bleeding disorder

Yes/No

Social History

Father's Age

Father's Health

Good

Fair

Poor

Mother's Age

Mother's Health

Good

Fair

Poor

Brother's Age(s)

Brother's Health

Good

Fair

Poor

Sister's Age(s)

Sister's Health

Good

Fair

Poor

Breast fed or Bottle fed as infant

Attends Daycare

Yes/No

how long?

in home or center?

Grade Level in School

Second Hand Smoke Exposure

Yes/No

Family History

Life threatening problems with Anesthesia

Yes/No

Bleeding Disorders

Yes/No

Hearing Loss

Yes/No

Malignant Hyperthermia

Yes/No

Other

Other Speciality Physicians Your Child May See

please list physician name and their speciality

Thank you for taking the time to complete this information for your child.