

Northland Ear, Nose & Throat, P.C.
Pediatric Medical History Form
www.northlandent.com

Today's Date

Legal Name: _____ Current Age: _____ Date of Birth: _____
 Male Female Height : _____ Weight: _____
Family Physician: _____ Referring Physician: _____

Reason for being seen today (Please list your symptoms): _____

Onset of symptoms: _____

How severe are your symptoms at this time:

- No longer present
- Mild
- Moderate
- Severe
- Disabling

List the medications used to treat your symptoms:

(Include non-prescriptions)

Current Medications (Including Non-Prescriptions):

Medication:	Dose:	How often do you take the medication?
_____	_____	_____
_____	_____	_____
_____	_____	_____

List the medications that your child has had **within the last six months:**

_____	_____	_____
_____	_____	_____
_____	_____	_____

Past Medical History:

Do you have a history of

- | | |
|--|---|
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Bronchitis |
| <input type="checkbox"/> Heart rhythm problems | <input type="checkbox"/> Kidney disease |
| <input type="checkbox"/> Anemia (low red blood cell count) | <input type="checkbox"/> Other urinary tract disease |
| <input type="checkbox"/> Bleeding disorders | <input type="checkbox"/> Hepatitis or liver disease |
| <input type="checkbox"/> Frequent ear infections | <input type="checkbox"/> AIDS or HIV positive status |
| <input type="checkbox"/> Hearing loss | <input type="checkbox"/> Spine problems |
| <input type="checkbox"/> Frequent sore throat | <input type="checkbox"/> Diabetes <input type="checkbox"/> Neurological problems |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Cancer <input type="checkbox"/> Other major illnesses (list) |

Comments: _____

Past Surgeries or Trauma History:

Please mark any prior surgeries and the date completed next to it.

- | | |
|---|--|
| <input type="checkbox"/> Tonsillectomy/Adenoidectomy | <input type="checkbox"/> Hernia repairs |
| <input type="checkbox"/> Ear or mastoid surgery | <input type="checkbox"/> Pyloromyotomy |
| <input type="checkbox"/> Placement of ear tubes | <input type="checkbox"/> Appendectomy |
| <input type="checkbox"/> Removal of lymph nodes from neck | <input type="checkbox"/> Repair of fractures |
| <input type="checkbox"/> Thyroid gland surgery | <input type="checkbox"/> Anesthesia difficulties |
| <input type="checkbox"/> Other head or neck surgery | <input type="checkbox"/> Spine surgery |
| <input type="checkbox"/> Heart surgery | <input type="checkbox"/> Excessive bleeding |
| <input type="checkbox"/> Other (please list) _____ | |

CONTINUED ON BACK SIDE

Family Medical History:

Is there a family history of heart disease, stroke, cancer, hearing loss, diabetes, thyroid, etc? Please list details:

Social/Psycho-Social History:

Daycare Second-hand smoke exposure Family unit support Child copes well

Allergy History/Drug Allergies:

Additionally, please list if there are any smokers in the household or pets living with your child.

Immunizations:

Is your child up to date on his or her immunizations? yes no

Systems Review:

Please check all that apply to your child:

Sleep: none loud snoring excessive daytime sleep trouble going to sleep trouble staying asleep

Constitutional: fever chills excessive weight loss or gain fatigue

Eyes: vision loss double vision tearing eyes worsening vision

Cardiovascular: palpitations racing heart chest pains cold/swollen extremities

Respiratory: wheezing dry cough productive cough night sweats shortness of breath

Gastrointestinal: increased/decreased appetite nausea vomiting abdominal pain diarrhea/constipation

Musculoskeletal: joint pain swelling stiffness muscle weakness

Integumentary: changes in skin lesion

Psychiatric: irritability depression anxiety insomnia drug or alcohol addiction (past or present)

Neurological: loss of smell or taste facial weakness or numbness memory problems headaches (how often)
 difficulty walking difficulty swallowing/speaking

Endocrine: increase in size of hands/feet heat/cold intolerance excessive thirst thyroid problems

Hematologic/Lymphatic: swollen nodes excessive bruising or bleeding

Allergic/Immunologic: allergy to medicines seasonal allergies

Additional: _____

Signature

Date

Relationship to the Child

