Welcome to our practice. Our goal is to provide you or your child with the highest quality of care. The first step is to learn all we can about your medical history. Please assist us by taking a few minutes to complete the following 2 pages . Our staff would be glad to assist you if needed. The care we give you can be no better than the information you provide.

Child's Name: _____ **Age**_____ **Date of Birth:**____/____/____ **Date:**_____

Who Referred you to us? ☐ Primary Physician ☐ Other Physician(s) ☐ Friend/Family Name:_____

Main Reason For Visit: Briefly describe_____

How Long have the symptoms been present?_____

What makes it better or worse?_____

Has your child taken any medications for this condition?_☐_Yes ☐ No If Yes, what kind?_____

How often does your child have these symptoms?_____

Have any tests been performed so far?_____

Medication Allergies	Type of Reaction		Medication Allergies	Type of Reaction

LIST ALL MEDICATIONS YOUR CHILD IS TAKING (Prescription, over-the-counter or herbal) ☐ **None**

Medication	Dosage	How often taken		Medication	Dosage	How often taken

Pharmacy Name (Include Address &/or Phone)_____

***MEDICAL HISTORY*: DOES YOU CHILD HAVE ANY OF THE FOLLOWING?**

☐ **No Past Medical History**

Cardiovascular:
Atrial Septal Defect ☐ **Yes**
Born with Heart Defect ☐ **Yes**
Any Heart Disorder ☐ **Yes**

Gastrointestinal:
Unpset Stomach / Gastritis ☐ **Yes**
Hernia ☐ **Yes**
Gastroesophageal Reflux ☐ **Yes**

Genitourinary:
Hypospadius ☐ **Yes**
Bed Wetting ☐ **Yes**
☐ **Yes**

Ear / Nose / Throat: (HEENT)
Lazy Eye ☐ **Yes**
Wears Glasses ☐ **Yes**
Chronic ear infections (otitis media) ☐ **Yes**
Hearing loss ☐ **Yes**
Sinus problems (chronic sinusitis) ☐ **Yes**
Nasal polyps ☐ **Yes**
Nasal allergies ☐ **Yes**
Recurrent tonsillitis ☐ **Yes**
Tinnitus ☐ **Yes**
Vertigo /Imbalance ☐ **Yes**

Hematologic :
Anemia ☐ **Yes**

Immunologic:
Allergies Type: _____ ☐ **Yes**
Food Allergies Type: _____ ☐ **Yes**
☐ **Yes**

Infectious Disease:
Mononucleosis ☐ **Yes**
☐ **Yes**

Metabolic/endocrine:
Diabetes Type: _____ ☐ **Yes**
Thyroid deficiency (hypothyroidism) ☐ **Yes**
☐ **Yes**

Neoplastic:
Cancer Type: _____ ☐ **Yes**

Neurologic:
Migraine ☐ **Yes**

Psychiatric:
Adjustment Disorder - Anxiety ☐ **Yes**
ADHD ☐ **Yes**
Developmental Delay ☐ **Yes**

Pulmonary:
Asthma ☐ **Yes**
RSV ☐ **Yes**
Sleep Apnea ☐ **Yes**
Bronchitis ☐ **Yes**

Miscellaneous:
Anesthesia Reaction ☐ **Yes**

Miscellaneous PEDIATRIC:
Complications during Pregnancy ☐ **Yes**
Complications during Delivery ☐ **Yes**
NICU stay >48hrs:_____ ☐ **Yes**
Preterm birth ☐ **Yes**

***SURGICAL HISTORY*: HAS YOUR CHILD EVER HAD ANY OF THE FOLLOWING SURGERIES?**

Tonsillectomy ☐ **Yes**
Adenoidectomy ☐ **Yes**
Ear Tubes ☐ **Yes**
Nasal Septoplasty ☐ **Yes**
Sinus Surgery ☐ **Yes**
Mastoid Surgery ☐ **Yes**
Palate Surgery ☐ **Yes**
Hernia Surgery ☐ **Yes**
Heart Surgery ☐ **Yes**
Eye Surgery ☐ **Yes**

Please List Any Other Surgeries

_____

_____

_____

_____

FAMILY HISTORY:

Hearing deficiency	☐ **Yes**	Seizure disorder	☐ **Yes**
Allergies	☐ **Yes**	Migraines	☐ **Yes**
Asthma	☐ **Yes**	Kidney disease	☐ **Yes**
Blood disease	☐ **Yes**	Other: _____	
Cancer Type: _____	☐ **Yes**		
Eczema	☐ **Yes**		
Diabetes	☐ **Yes**		

Exposed to second hand smoke? ☐ **Yes**
Caffeine Consumption? ☐ **Yes** **If Yes, Which type? Coffee / Tea / Colas** **How many per day? _____**
Is Your Child a Picky Eater ☐ **Yes** **Does Your Child Often Complain of an UpSet Stomach?** ☐ **Yes**

REVIEW OF SYSTEMS: Check any of the following problems your child may have recently had:

General health problems
☐fatigue ☐fever ☐night sweats ☐unintentional weight loss ☐sleeping problems ☐weight gain

Eye problems
☐double vision ☐itchy eyes ☐swelling ☐redness

Ear problems
☐ear drainage ☐hearing loss ☐ear infections ☐dizziness ☐itchy ☐noise exposure ☐ringing /noise in ears ☐ear pain ☐tinnitus

Nose & Sinus problems
☐chronic congestion ☐mouth breathing ☐nosebleeds ☐frequent sneezing ☐runny nose ☐post-nasal drip

Mouth & Throat problems
☐difficulty swallowing ☐snoring ☐sore throat ☐hoarseness ☐sores in mouth ☐ulcers

Heart or circulation problems
☐heart murmur ☐leg cramping ☐swelling of ankles ☐chest pain ☐blacking out ☐irregular heartbeat

Lung or respiratory problems
☐shortness of breath ☐wheezing ☐ cough

Stomach problems
☐abdominal pain ☐diarrhea ☐upset stomach ☐nausea ☐vomiting

Brain or Nervous system problems
☐headache ☐seizures ☐weakness ☐numbness ☐facial pain

Glands & Hormone problems
☐intolerance to heat ☐increased appetite ☐neck enlargement / lump on neck ☐intolerance to cold

Blood or Lymph nodes problems
☐bleeds excessively after injury ☐bruises easily

Allergy problems
☐food intolerances ☐insect bites

Skin
☐rash ☐itchy ☐latex allergies ☐swelling ☐urticaria / hives

DO NOT WRITE IN THIS SECTION FOR STAFF USE ONLY

EXAM VITALS: Temp_____HR_____RR_____BP_____

MOOD/AFFECT approp/non
A&Ox3 Yes No
Skin Moist Dry Flaking
Scalp Dry Flaking Oily Ulcers
Voice Clear Hoarse Breathy
Eyes EOMI PERRLA Entrap L R
REAC Clear Wax Dry Wet Pus Fungi
LEAC Clear Wax Dry Wet Pus Fungi
RTM Pearly Dull Retract Perf
AOM SOM Sclerosis
LTM Pearly Dull MEE Retract Perf
AOM SOM Sclerosis

Physician Signature_____
NOSE Ext Lesion Shift R L
SEPTUM Straight Dev R L
Obstruct %

TURBINATES Pink Edema Enlarged
NSL MUCOSA Pink Red Rhinorrhea
Pus
LIPS Moist Dry Lesion
TEETH/GUMS Good Repair Edentu
Caries Inflammed
TONSILS 0 1 2 3 4 Pus/Exud
PALATE Healthy Narrow Long
TONGUE PinkRed Large Lesion

NECK Soft Supple mass R L
Node R L Shoddy
SUBMAX Soft Mass Ptotic R L
PAROTID Soft Mass Tendr R L
THYROID Soft Large Nodule
CRANIAL N 3-12 Intact Defect

TMJ Mobile Tender R L
LARYNX Symetry Mass Nodule
Polyp Paralysis R L
LPR 1 2 3 4 5 6 7 8 9 10
LUNGS CTA Rhonchi Wheeze
HEART RRR Murmur Arrythm