BONNER GENERAL HEALTH
Ear, Nose & Throat

PEDIATRIC PATIENT HEALTH HISTORY
(PLEASE PRINT FILL OUT COMPLETELY) **Date:**_____

Patient name _____ DOB_____ Age _____
School/Daycare _____

Medical History/Birth History

Method of delivery? [ ] Normal Vaginal [ ] Cesarean Section

Were there any complications or infections during pregnancy? [ ]No [ ] Yes
If Yes, please explain: _____

Was child premature? [ ] No [ ] Yes If yes, gestational age at birth _____weeks

Was child in NICU? [ ] No [ ] Yes If yes, was child intubated? [ ] No [ ] Yes

Did child pass newborn hearing screen? [ ] No [ ] Yes [ ] Unsure

Is/was child breastfed? [ ] No [ ] Yes

Please indicate any therapy child is receiving: [ ] PT [ ] OT [ ] Speech Other: _____

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

Have you refused/declined any immunizations? [ ] No [ ] Yes If yes, which one(s)? _____

Does your child have or ever had and of the following conditions? Please check:

☯ ☸ Behavior/developmental disorders:

☯ ☸ Ear infections. If yes, how many in past 12 months:
_____

☯ ☸ Easy bruising/bleeding disorder:
_____

☯ ☸ Heart problems/has child seen cardiologist:
_____

☯ ☸ Stomach or intestinal problems:
_____

☯ ☸ Strep throat or tonsillitis. If yes, how many episodes in past 12 months:
_____

☯ ☸ Asthma
☯ ☸ Bladder/urinary tract infections (UTIs)
☯ ☸ Bronchitis/pneumonia
☯ ☸ Cancer/leukemia
☯ ☸ CMV exposure
☯ ☸ Cystic fibrosis
☯ ☸ Diabetes
☯ ☸ Headache/migraine
☯ ☸ Jaundice
☯ ☸ Meningitis
☯ ☸ Seizures
☯ ☸ Thyroid disease
☯ ☸ Tuberculosis

Do you think your child hears normally? [ ] No [ ] Yes

Has anyone else (family/teachers) expressed concern about your child's hearing or speech? [ ] No [ ] Yes

PLEASE SEE REVERE SIDE

Please list other medical conditions your child may have:

_____

_____

_____

Previous Surgery
Has you child had any surgeries? [ ] No [ ] Yes (please list below)

Surgery	Date/Approximate date

Medications
Is your child currently taking any prescribed or over the counter medicines? [ ] No [ ] Yes (please list below)

Medication	Dosage	Reason for taking

Is your child allergic to any medications? [ ] No [ ] Yes (please list below)

Medication	Type of reaction

Family History
Is there a family history(immediate family only) of medical problems? [ ] No [ ] Yes

[ ] Heart disease [ ] Diabetes [ ] High blood pressure
[ ] Bleeding problems [ ]Hearing loss before age 50 [ ] Stroke
[ ] Cancer [ ] Anesthesia problems [ ] Other:

Social History
Does your child attend daycare? [ ] No [ ] Yes

Does anyone smoke around your child? [[No [ ] yes If Yes, describe exposure: _____

Are there pets at home? [ ]No [ ] Yes If Yes, number/types: _____

Who does the child live with? (include siblings): _____
Number of languages spoken at home: _____

What grade is your child in? _____ Problems with poor academic performance? [ ] No [ ] Yes

Do siblings have/history ear infections? [[No [ ] Yes

Does child use a pacifier? [ ] No [ ] Yes

Review of systems(please check only those symptoms your child has developed)

Constitutional:
[ ]Anxiety
[ ]Chills
[ ]Fatigue
[ ]Fever
[ ]Headache
[ ]Weight gain How much _____
[ ]Weight loss How much _____

Ear, Nose, Throat:
[ ] Ear drainage
[ ] Ear pain
[ ] Difficulty swallowing
[ ] Hay fever
[ ] Hoarseness
[ ] Loss of hearing
[ ] Nosebleeds
[ ] Post nasal drip
[ ] Sinus problems
[ ] Snoring/gasping in sleep

Eye:
[ ]Blurred Vision
[ ]Double Vision

Neurological:
[ ] Balance problems
[ ] Fall asleep easily during the day/at school
[ ] Headaches
[ ] Seizure
[ ] Tremors

Gastrointestinal:
[ ] Acid reflux
[ ] Constipation
[ ] Diarrhea
[ ] Nausea
[ ] Poor appetite
[ ] Vomiting

Respiratory:
[ ] Mouth breathing
[ ] Persistent cough
[ ] Productive Cough
[ ] Shortness of breath
[ ] Wheeze
[ ] Exercise/play intolerance

Musculoskeletal:
[ ] Joint pain
[ ] Muscle pain
[ ] Muscle weakness
[ ] Neck stiffness
[ ] Teeth grinding

Skin:
[ ] Bruise easily
[ ] Hives
[ ] Itching
[ ] Rash
[ ] Scars
[ ] Sores that won't heal

Girls Only:
[ ] Abnormal pap smear
[ ] Unusually heavy menstrual periods