Michigan ENT & Allergy Specialists New Pediatric Patient Health History

Name: _____Date of Birth:_____Date: _____

Preferred Pharmacy: _____Height: _____ Weight: _____

Pediatrician: _____Parent/Guardian Names: _____

Email: _____Preferred Language: _____

Race: _____ Ethnicity (Circle one): Hispanic Non-Hispanic Other

Please list family members that are patients or have been seen in our office: _____

Please answer the following the best you can. Some of these may be difficult to answer and the medical staff will assist you when you are brought to the exam room. Anything left blank will be assumed normal / not present.

What is the reason for today's visit? _____

Does your child have a history of hearing loss or difficulty? ❑ Yes ❑ No

Where is the location of the problem? _____

How often does it occur? How long has it occurred? _____

Is it painful? If so, please explain: _____

Is it getting worse, improving, or staying the same? _____

What are some things that make it better or worse? _____

Other symptoms: _____

Please complete both front and back of this questionnaire.

MEDICATIONS:

List all prescription and nonprescription medicines, or provide list.

Medicine	Dose	**How often**
Example: Aspirin	81 mg	once a day

ALLERGIES / SENSITIVITIES

Penicillin Allergy? ❑ No ❑ Yes. Reaction: _____

Environmental? ❑ No ❑ Yes: _____

Other Medication Allergies	**Side Effects/Reaction**

BIRTH/SOCIAL HISTORY

Was your child a product of a normal pregnancy and delivery? ❑ Yes ❑ No Explain: _____

Is your child in a day care setting? ❑ Yes ❑ No Explain: _____

Does any family member smoke in the household or car? ❑ Yes ❑ No Explain: _____

Are your child's immunizations up to date? ❑ Yes ❑ No Explain: _____

PAST SURGICAL / MAJOR ILLNESS HISTORY (List as accurately as possible what, when, and why.)

1. _____
2. _____
3. _____
4. _____

FAMILY HISTORY – Do any of <u>your family members</u> have the following?

	YES	NO	RELATIONSHIP	EXPLAIN
Diabetes	❑	❑	_____	_____
High blood pressure	❑	❑	_____	_____
Heart disease	❑	❑	_____	_____
Cancer	❑	❑	_____	_____
Hearing loss	❑	❑	_____	_____
Asthma	❑	❑	_____	_____
Stroke	❑	❑	_____	_____
Respiratory failure	❑	❑	_____	_____
Bleeding disorders	❑	❑	_____	_____
Anesthetic complications	❑	❑	_____	_____
Other inherited diseases	❑	❑	_____	_____

PATIENT MEDICAL HISTORY – Pertaining <u>only</u> to the patient

	YES	NO	EXPLAIN
Anesthetic complications	❑	❑	_____
Eye penetrating injury involving metal	❑	❑	_____
Claustrophobia	❑	❑	_____
Bleeding Problems	❑	❑	_____
Cancer	❑	❑	_____
Skin changes	❑	❑	_____
Ear, Nose, Throat problems (unrelated to today's visit)	❑	❑	_____
History of fever, weight loss or chills	❑	❑	_____
Visual Changes	❑	❑	_____
Hearing problems or ringing in the ears	❑	❑	_____
Dizziness/vertigo	❑	❑	_____
History of noise exposure	❑	❑	_____
Are you pregnant (women only)	❑	❑	_____
Cardiovascular problems (ex: Heart attack, chest pain)	❑	❑	_____
Respiratory problems (ex: Asthma, wheezing)	❑	❑	_____
Gastrointestinal problems (ex: Bloody stools, ulcers)	❑	❑	_____
Genitourinary problems (ex: Painful, bloody urination	❑	❑	_____
Musculoskeletal problem (ex: Arthritis)	❑	❑	_____
Neurological problems (ex: Stroke, seizures)	❑	❑	_____
Psychiatric problems (ex: Depression, anxiety)	❑	❑	_____
Endocrine problems (ex: Diabetes, low thyroid)	❑	❑	_____
Immune problems (ex: AIDS, immune deficiencies)	❑	❑	_____

Signature_____