Ear, Nose & Throat *SpecialtyCare* of Minnesota, P.A.

Pediatric Medical History Form

Today's Date______________________________

PATIENT NAME: Please print (If you need help filling out this form let our receptionist know)

____Birth Date: _____/_____/____Age____

(First) (M) (Last)

Name of your child's doctor (s)____

Name of person who sent you to us: ____

Reason for visit: ____

I. PAST MEDICAL HISTORY

- Birth/Pregnancy Problems ____ [ ] Yes [ ] No
  ____
- Newborn Problems ____ [ ] Yes [ ] No
  ____
- Serious Illnesses ____ [ ] Yes [ ] No
  ____
- Does your child have a syndrome? ____ [ ] Yes [ ] No
  ____
- Previous Hospitalizations ____ [ ] Yes [ ] No
  ____
- Allergies
  To medications (Please List) ____ [ ] Yes [ ] No
  ____
  Others (Hayfever, foods, latex) ____
  ____
- Previous Surgeries? (Please List) [ ] No
  ______________________________Date______________
  ______________________________Date______________
  ______________________________Date______________
- Problems with anesthesia? [ ] Yes [ ] No
  Type of reaction ____
- Does your child have a blood clotting or bruising problem? [ ] Yes [ ] No
- MEDICATIONS

  Current prescription drugs ____
  ____
  ____
  ____

  Over the counter drugs (Tylenol, cold medicine) or herbal medications (i.e., Gingko, St. John's Wort) ____
  ____
  ____
  ____

PLEASE SEE OTHER SIDE

II. REVIEW OF SYSTEMS - Circle either "no problems" or the individual problems for each area.

ENT	Constitutional	Heart	Lungs	Digestive
No Problems	No Problems	No Problems	No Problems	No Problems
Ear Pain	Weight Loss	Murmur	Shortness Breath	Swallowing Problems
Hearing Loss	Night Sweats	Other Problems	Chronic Cough	Vomiting
Balance Problem	Fever		Asthma (Wheezing)	
Nasal Congestion/Drainage	Fatigue		TB (Tuberculosis)	
Sore Throat/Tonsillitis				
Hoarseness				
Lump in Neck				
Weak Cry				
Snoring				
Mouth Breathing				

Neurologic	Endocrine	Skin	Eyes	Blood
No Problems	No Problems	No Problems	No Problems	No Problems
Seizures	Diabetes	Hives	Abnormal Tearing	Anemia
Headaches	Thyroid Disease		Visual Problems	Sickle Cell
Weakness				
Numbness				

III. SOCIAL AND FAMILY HISTORY

- Do any household members smoke? [ ] Yes [ ] No
- Is your child in Day Care? [ ] Yes [ ] No

  How many other children at that Day Care? _________
- Do you have any pets? ____ [ ] Yes [ ] No

FAMILY HISTORY

- Ear Infections?____ [ ] Yes [ ] No
- Environmental Allergies?____ [ ] Yes [ ] No
- Anesthetic Problems?____ [ ] Yes [ ] No
- Bleeding/Bruising Problems?______________________________________ [ ] Yes [ ] No

Physicians use only: Date & Initial: ☐ Anti-smoking education reviewed

____

____

____

____

____