OTO/HNS (ENT) PEDIATRIC PATIENT FORM

Date of previous visit: ______________

Reason for today’s visit (CC) ____________________________________________________________________________________ Date:______________

In order for the physician to better serve your child’s healthcare needs we ask that you complete this form prior to seeing the physician. We appreciate you taking the time to complete this detailed form.

**EAR, NOSE AND THROAT**

<table>
<thead>
<tr>
<th>Question</th>
<th>No</th>
<th>Yes</th>
<th>How many in the last 12 months</th>
<th>How many in the last 24 months</th>
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<tbody>
<tr>
<td>Recurrent sore throat episodes?</td>
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<td>Strep positive?</td>
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<td>Bad breath?</td>
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<td>Does your child usually snore?</td>
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<td>Does your child sleep with an open mouth?</td>
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<td>Have you witnessed your child gasping for air during his sleep?</td>
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<td>Have you witnessed your child struggling to breath during sleep?</td>
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<td>Would you describe your child as having restless sleep?</td>
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<td>Would you describe your child as difficult to arouse in the morning?</td>
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<td>Has your child ever been diagnosed with malocclusion (protruding teeth)?</td>
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<td>Does your child tend to take naps in the afternoon?</td>
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<td>Does your child tend to doze off frequently?</td>
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<td>How would you describe your child’s day time alertness/energy?</td>
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<td>Does your child have seasonal allergies?</td>
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</tbody>
</table>

Please mark which manifestations are typical for your child’s allergies:

- □ high
- □ fair
- □ poor
- □ extremely poor

- □ clear nasal drainage
- □ sneezing
- □ watery eyes
- □ black circles around eyes
- □ itchiness

If yes, results: ____________________________

If yes, frequency: ____________________________

- □ normal
- □ difficult to breath through
- □ completely blocked

- □ usually normal
- □ diminished

- □ great
- □ fair
- □ poor

- □ very good
- □ fair
- □ poor

Only answer the next question if your child is less than 5 years old:

How many words does your child have in his/her vocabulary?

Has your child ever had ear surgery including tubes?  □ No □ Yes

If yes, when: ____________________________
Has your child ever been diagnosed with cholesteatoma? □ No □ Yes
How many acute ear infections has your child had in the past…
□ No □ Yes

Has your child ever had a hearing test? □ No □ Yes

Has your child ever participated in speech therapy classes? □ No □ Yes
Has your child ever been diagnosed with attention deficit? □ No □ Yes

Does your child have known acid reflux disease? □ No □ Yes
If yes, treatment ______________________________

Does your child have night time cough? □ No □ Yes
Does your child have spitting out episodes? □ No □ Yes
Does your child have heartburn? □ No □ Yes
Does your child have frequent throat clearance? □ No □ Yes

How would you describe your child’s voice? □ clear □ hoarse/raspy □ changes

GENERAL INFORMATION
Is your child a product of normal pregnancy? □ No □ Yes
If no, please explain ______________________________
(infections, pre-eclampsia, diabetes, etc):
____________________________

Is your child a product of a vaginal delivery or C-section? □ vaginal delivery □ C-section
Reported complications after delivery? □ No □ Yes
If yes, please explain ______________________________

Child birth weight
Has your child ever been kept in ICU? □ No □ Yes
Has your child ever been intubated (tube for ventilation)? □ No □ Yes
Has your child been diagnosed with Jaundice to a level requiring special therapy? □ No □ Yes

How many days after birth did you stay in the hospital with your baby?
Immunizations up-to-date? □ No □ Yes
If no, please explain ______________________________

Feeding: did you/are still experiencing feeding difficulties? □ No □ Yes
If yes, please explain ______________________________
Was your child gaining weight normally? □ No □ Yes
If no, please explain ______________________________

Has your child ever had noisy breathing (strider) as an infant? □ No □ Yes
If yes, please explain ______________________________
Has your child has motor/mental developmental delays during infancy? □ No □ Yes
If yes, please explain ______________________________

PAST MEDICAL HISTORY
□ asthma
□ allergy
□ diabetes
□ ADHD
□ language developmental delays
□ sickle cell disease
□ anemia
□ obesity
SURGICAL HISTORY
☐ adenoids
☐ tonsils
☐ tubes
☐ nasal surgery
☐ sinus surgery
☐ other __________________________

MEDICATIONS
_________________________________
_________________________________
_________________________________

ALLERGIES
________________________________
________________________________
________________________________

REVIEW OF SYSTEMS
Has your child ever had:

Allergies  ☐ No  ☐ Yes
Allergy testing  ☐ No  ☐ Yes
Asthma or lung disease  ☐ No  ☐ Yes
Bleeding disorder  ☐ No  ☐ Yes
Developmental problems  ☐ No  ☐ Yes
Endocrine disorder  ☐ No  ☐ Yes
Eye problems  ☐ No  ☐ Yes
Gastrointestinal disease/reflux  ☐ No  ☐ Yes
Genitourinary disease  ☐ No  ☐ Yes
Heart disease  ☐ No  ☐ Yes
Immune dysfunction  ☐ No  ☐ Yes
Muscle disorder  ☐ No  ☐ Yes
Neurologic problems/seizures  ☐ No  ☐ Yes
Skin disorder or eczema  ☐ No  ☐ Yes
Syndrome  ☐ No  ☐ Yes

Social History
Daycare/school  ☐ No  ☐ Yes
Lives with both parents  ☐ No  ☐ Yes
Smoking in house  ☐ No  ☐ Yes
Smoking in car  ☐ No  ☐ Yes

FAMILY HISTORY
☐ history of hearing loss diagnosed in childhood  ☐ nasal allergy
☐ history of asthma  ☐ genetic syndrome
☐ history of diabetes  ☐ bleeding tendencies
☐ sickle cell disease
☐ congenital abnormalities (clef palate, blood disorder, etc)
☐ other, please specify____________________________

Form Completed by ________________________________  Legal Guardian?  Yes / No

Relationship to Child ______________________________