Pediatric Medical History Form

Name: _____ Birth Date: _____ Today's Date: _____

Please list the main concern for today's visit:
_____
_____

How long has the child experienced this problem?_____
_____

What other treatments has your child tried for this problem?_____
_____
_____

Prior ENT visits? YES NO

How did you hear about our clinic? (doctor, friend, internet, etc)_____

Does your child have medication allergies?
YES NO If yes, please list:_____
_____

Does your child take medications, including nasal sprays, herbal medication and over-the-counter medications? YES NO
If yes, please list:____ _____
_____ _____
_____ _____

How often does your child get sick?_____
_____

Was your child full term at birth? YES NO

Please list any prior surgeries: _____
_____ _____
_____ _____
_____ _____

Please list the medical problems the child has been treated for:_____ _____
_____ _____
_____ _____
_____ _____

Does anyone use tobacco around the child? YES NO What type? _____

For older children, does the child use tobacco, alcohol, e-cigarettes or illicit drugs? YES NO
If yes, please describe: _____

Who lives in the household? _____
_____

Does the child attend daycare, preschool or school? If so, what grade?_____

Please list any medical problems that run in your family: _____
_____

Has anyone in your family had difficulty with anesthesia, easy bleeding or bruising? YES NO

Preferred pharmacy: _____

Has your child had any of the following? YES NO If yes, please check or circle

Frequent/recent headaches	Liver disease or hepatitis	Urinary tract infections
Migraines	Breathing difficulty	Difficulty urinating
Weakness in arms or legs	Coughing up blood	Kidney stones
Numbness	Pneumonia	Prostate enlargement
Stroke or aneurysm	Tuberculosis	Unusual vaginal bleeding
Changes in eyesight	Syphilis	Night Sweats
Fainting spells/dizziness	Ankle swelling	Blood in the urine
Glaucoma or cataracts	Stomach problems	High blood pressure
Eye surgery	Ulcers	Diabetes
Ringing in the ears	Indigestion or heartburn	Thyroid problems
Heart problems	Rectal bleeding/dark stools	Fevers/Chills
Angina or chest pain	Constipation or diarrhea	Weight loss
Heart rhythm problems	Gallstones	Depression
Heart failure	Gallbladder surgery	Easy bleeding/bruising
Heart surgery	New or changing moles	Problems at birth
Arthitis or joint pain	Recent skin changes	Cancer/Leukemia

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