SAN FRANCISCO
OTOLARYNGOLOGY
Providing ear, nose, and throat care since 1940

PEDIATRIC HEALTH HISTORY FORM

NAME:_____ DOB:_____WEIGHT: _____

PREFERRED NAME (if other):_____Visit date:_____

Who referred you to our office?_____Pediatrician:_____

What is the **Main Reason** for your child's visit today? _____

_____

How long has this problem existed? _____

ALLERGIES/SENSITIVITIES TO MEDICATIONS: (Please describe reaction) □ *NONE*

CURRENT MEDICATIONS WITH DOSAGE: (Please include over the counter and herbal supplements) □ *NONE*

PAST MEDICAL HISTORY: □ *NONE*

Allergies	Y	N	Hepatitis	Y	N
Anemia	Y	N	Kidney disease	Y	N
Asthma	Y	N	Liver disease	Y	N
Bleeding disorder	Y	N	Pneumonia/Lung disease	Y	N
Cancer	Y	N	Premature birth	Y	N
Depression	Y	N	Psychiatric disorder	Y	N
Diabetes mellitus	Y	N	Seizures	Y	N
Ear infection	Y	N	Sinus problem	Y	N
GERD (Reflux)	Y	N	Sleep apnea	Y	N
Hearing loss	Y	N	Speech delay	Y	N
Heart disease	Y	N	Thyroid disease	Y	N

OTHER MEDICAL PROBLEMS:_____

_____

PAST SURGICAL HISTORY:_____

_____

FAMILY HISTORY: *(M=mother; F=father; S=sister; B=brother)* □ Adopted

	M	F	S	B
Allergies				
Anesthesia problems				
Asthma				
Bleeding disorder				
Cancer (type:)				
Diabetes				
Genetic disease				

	M	F	S	B
Hearing loss				
Heart disease				
High blood pressure				
Kidney disease				
Psychiatric illness				
Stroke				
Sudden death				

BIRTH HISTORY:
Birth Weight: _____lbs. _____oz. How many weeks gestation?_____
Pregnancy complications (list any)_____
NICU stay? Y N Newborn hearing screen results: Pass Fail Unknown

IMMUNIZATIONS: Up to date or delayed? _____

SOCIAL HISTORY: Circle all that apply
Who has legal custody? Mother Mother Father Father Other_____
Child lives with: Mother Mother Father Father Other_____
Parents are: Married Not married Partnered Separated Divorced
Does your child attend: Daycare Preschool Grade in school?_____
Number of siblings:_____

REVIEW OF SYSTEMS: Indicate symptoms that your child is *currently* experiencing

□ Appetite change	□ Cough	□ Mental status changes
□ Low energy	□ Wheezing	□ Weakness
□ Fever/chills/night sweats	□ Nausea/vomiting	□ Headache
□ Weight loss	□ Abdominal pain	□ Anxiety
□ Vision changes	□ Change in bowel habits	□ Bleed easily
□ Difficulty breathing	□ Skin rash	□ Bruise easily

Form completed by (print):_____

Relationship to patient: Mother Father Other:_____

Signature:_____ Date:_____