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

PEDIATRIC FORM

NAME:_____ DOB:_____WEIGHT: _____

Visit date:_____ Referral/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:

Allergies	Y	N	Hypertension	Y	N
Anemia	Y	N	Kidney disease	Y	N
Arthritis	Y	N	Language delay	Y	N
Asthma	Y	N	Liver disease	Y	N
Bleeding disorder	Y	N	Lung disease	Y	N
Cancer	Y	N	Pneumonia	Y	N
Chronic bronchitis	Y	N	Psychiatric Treatment	Y	N
Depression	Y	N	Seizures	Y	N
Diabetes mellitus	Y	N	Sinus disorder	Y	N
Ear infection	Y	N	Sleep Apnea	Y	N
GERD	Y	N	Speech delay	Y	N
Hearing aid	Y	N	Stomach ulcers	Y	N
Hearing loss	Y	N	Thyroid disease	Y	N
Heart disease	Y	N	Tuberculosis	Y	N
Hepatitis	Y	N	Urinary tract infection	Y	N
HIV/AIDS	Y	N			

OTHER MEDICAL PROBLEMS:_____

_____

PAST SURGICAL HISTORY:_____

_____

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

	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 of the child? Mother Father Other
Child lives with: Mother Father Other family Foster family
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
□ Low energy
□ Fever/chills/night sweats
□ Weight loss
□ Vision changes
□ Difficulty breathing
□ Wheezing
□ Nausea/vomiting
□ Abdominal pain
□ Change in bowel habits
□ Pain with urination
□ Joint pain/swelling
□ Skin rash
□ Mental status changes
□ Weakness
□ Headache
□ Anxiety
□ Bleed easily
□ Bruise easily

PREVIOUS TESTS PEFORMED: please indicate ***type of test, date, and where.***
Allergy test Y N _____
Hearing test Y N _____
X-ray, CT, MRI Y N _____
Genetic test Y N _____

Form completed by (print):_____
Relationship to patient: Mother Father Other:_____
Signature:_____ Date:_____