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? _____

EARS, NOSE AND THROAT HISTORY: Check all that apply

□ Hearing problems
□ Ear infections # in 6 mos____, 1 yr ____
□ Sinus infections
□ Nasal discharge
□ Nasal obstruction/mouth breathing
□ Cough
□ Noisy breathing
□ Snoring/sleep problem
□ Tongue tie
□ Frequent sore throats
□ Strep throat # this year___ , 2 yrs ago ___
□ Swallowing problem
□ Speech delay
□ Hoarseness
□ Sores/ulcers in mouth
□ Head trauma
□ Swollen lymph nodes

ALLERGIES TO MEDICATIONS: □ *NONE*

_____

_____

List any of the child's other allergies, such as to food, pollen, eggs, iodine, shellfish, latex, etc. □ *NONE* _____

MEDICATIONS: List all prescription and NON-prescription medications (such as Motrin, vitamins, herbal supplements, Mucinex and Tylenol) that your child is taking. □ ***NONE***

_____

_____

PAST MEDICAL HISTORY: If yes, please specify

Abnormal development	Y	N	Heart disease	Y	N
Allergies	Y	N	Immune disorder	Y	N
Arthritis	Y	N	Lung disease	Y	N
Asthma	Y	N	Muscle/bone disorder	Y	N
Attention deficit disorder	Y	N	Neurological disorder	Y	N
Bleeding disorders	Y	N	Seizures	Y	N
Depression	Y	N	Skin rash	Y	N
Down syndrome	Y	N	Thyroid disorder	Y	N
Eye disease	Y	N	Urinary/kidney disorder	Y	N
GI disorder/Reflux	Y	N			

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

PAST HOSPITALIZATIONS/SURGERIES: Indicate year and the reason

_____

_____

IMMUNIZATIONS: Up to date or delayed? _____

SOCIAL HISTORY: Circle all that apply
Who has legal custody of the child? Both parents Mother Father Other
Child lives with: Both parents 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:_____ Pets in the home? Dog Cat Other_____

FAMILY HISTORY: *Mark boxes below (M = mother, F = father, S = sibling)*

	M	F	S
Allergies			
Problems w/ anesthesia			
Asthma			
Bleeding problems			
Cancer (type:)			
Diabetes			
Genetic disease			

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

REVIEW OF SYSTEMS: Check all that apply

□ 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:_____