PEDIATRIC FORM – San Francisco Otolaryngology Medical Group

NAME:_________________________________ DOB:____________WEIGHT: ______
Visit date:____________________ 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

| Condition | | | Condition | | |
|---|---|---|---|---|---|
| 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_____________

Smokers in the house, even if they do not smoke inside? Yes No

**FAMILY HISTORY**: Check all the apply for your child's siblings, parents, grandparents

□ Problems w/ anesthesia
□ Problems with bleeding
□ Cancer_______________
□ Diabetes
□ High blood pressure
□ Stroke
□ Psychiatric illness
□ Hearing loss
□ Allergies
□ Asthma
□ Heart disease
□ Kidney disease
□ 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
□ Increased thirst
□ Bleed/bruise easily

**PREVIOUS TESTS PEFORMED:** please indicate ***type of test, date, and where.***

Allergy test Y N _____________________________________________

Sweat test Y N _____________________________________________

Hearing test Y N _____________________________________________

X-ray, CT, MRI Y N _____________________________________________

Genetic test Y N _____________________________________________

Immune test Y N _____________________________________________

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Form completed by (print):_______________________________________________

Signature:______________________________________ Date:__________________