1. Medical History

DO YOU HAVE OR HAVE YOU EVER HAD (please check box)

☐ No Known Medical Conditions
☐ Anesthesia Problems (specify ______________________)
☐ Bleeding Disorder (specify ______________________)
☐ Hearing Loss
☐ Ear Infections
☐ Ruptured Ear Drum
☐ Sinusitis
☐ Facial Trauma
☐ Tonsillitis (chronic)
☐ Heart Disease
☐ Hypertension
☐ High Cholesterol
☐ Arrhythmia
☐ Other Cardiac Disorder (specify____________________)
☐ Asthma
☐ Sleep / Snoring Problems (specify________________)
☐ Other Lung Disease (specify____________________)
☐ Stomach Ulcers / Colitis
☐ GERD (Reflux)
☐ Other Stomach Disorder (specify__________________)
☐ Acute Renal Failure
☐ Kidney Stones
☐ Other Renal Disease (specify____________________)
☐ Musculoskeletal Disorder (specify________________)
☐ Diabetes (specify___________________________ controlled ?____)
☐ Osteoarthritis
☐ Osteoporosis
☐ Thyroid Disease (specify______________________)
☐ Other Endocrine Disorder (specify________________)
☐ Headache /Migraine
☐ Seizures (specify______________________________)
☐ Stroke/TIAs (specify___________________________)
☐ Other Neurologic Disorder (specify________________)
☐ Anemia (Iron Deficiency, Hemolytic or Pernicious)
☐ Environmental Allergies
☐ Chicken Pox
☐ Immune Deficiency
☐ Other Allergy (specify__________________________)
☐ History of Cancer: Type: ____________________________

Diagnosed:______ Treatment:______________________
☐ Psychiatric Disorder (specify______________________)
☐ Do you have any other disease or condition that you think the
  doctor should know about?_________________________

2. Specialists

List any other doctors that you see:__________________________________________

_________________________________________

3. Surgical History

☐ No Surgical History
☐ Ear Tubes: when________  ☐ Septoplasty: when_______
☐ Tonsils: when_______  ☐ Sinus Surgery: when_______
☐ Adenoids: when_______
☐ Thyroid (partial, total): when_______
☐ Cardiac Stent: when________
☐ Coronary Artery Bypass: x ______, when __________
☐ Joint Replacement: (specify ___________): when________

Please list any additional operations (and dates) that you have had. _________________________________

4. Family History

☐ No Known Medical Conditions
☐ Anesthesia Problems (specify____________________)
☐ Bleeding Disorder (specify____________________)
☐ Hearing Loss: Relationship:_______________________
☐ Sinusitis
☐ Heart Disease
☐ Hypertension
☐ High Cholesterol
☐ Other Cardiac Disorder (specify____________________)
☐ Asthma
☐ Other Lung Disease (specify____________________)
☐ GERD (Reflux)
☐ Other Stomach Disorder (specify________________)
☐ Renal Failure
☐ Other Renal Disease (specify____________________)
☐ Rheumatoid Arthritis
☐ Lupus
☐ Musculoskeletal Disorder (specify________________)
☐ Thyroid Disease (specify________________________)
☐ Other Endocrine Disorder (specify________________)
☐ Headache /Migraine
☐ Seizures (specify______________________________)
☐ Stroke/TIAs (specify____________________________)
☐ Vertigo
☐ Other Neurologic Disorder (specify________________)
☐ Allergy/Immune/Skin (specify________________)
☐ Cancer: Type:_______ Relationship:________________
  Type:_______ Relationship:________________________
☐ Psychiatric Disorder (specify____________________)

For Women Only

☐ Are you pregnant, or is there any chance that you might be pregnant?
☐ Are you nursing?
5. Social History - Pediatric

Daycare/School: Name: ___________________________
Grade Level: ________________________________

Parent’s Marital Status:  □ Single  □ Married  □
□ Partnered  □ Divorced  □ Widowed

□ Lives with ___________

Legal Guardian: Name: ___________________________
Relation: ________________________________

Tobacco:  □ Never  □ Current  □ Past
Exposure From: ________________________________
Pets: _______________________________________

6. Prior Testing

□☐ Allergy Testing: Skin or Blood Test?  When_________  Sensitivities: ________________________________

□☐ Immuno Therapy: When:______ Duration:_______

□☐ CT Scan of the Sinuses or Neck
When_______ Where________

□☐ MRI of the Brain or Neck
When_______ Where________

□☐ Swallow Study
When_______ Where________

□☐ Ultrasound of the Neck
When_______ Where________

7. Immunizations & Vaccines

Have you received a flu immunization for this season (Oct-Mar)
□☐ Yes When_________  □☐ No

8. Current Symptoms

What is your main symptom? __________________________
When did this symptom start? ________________________
How Frequent? _______ Rate the Severity (1-10)_______
Quality (eg. pain, pressure, shooting)_________________

____________________________________________________
____________________________________________________
____________________________________________________
____________________________________________________
____________________________________________________

9. Review of Systems

DO YOU HAVE OR HAVE YOU EVER HAD (please check box)

Ear
□☐ Ear Pain  R - L - Both
□☐ Hearing Loss  R - L - Both
□☐ Ear Drainage  R - L - Both
□☐ Noises in Ear  R - L - Both

Nose
□☐ Nasal Obstruction
□☐ Sinus Pressure or Pain
□☐ Abnormal Sense of Smell
□☐ Runny Nose

Throat
□☐ Sore Throat
□☐ Hoarseness
□☐ Snoring/Sleep Apnea
□☐ Throat Clearing
□☐ Swallowing Problems

Eyes
□☐ Eye Pain
□☐ Itching or Watery Eyes

Heart / Chest
□☐ Chest Pain
□☐ Dizziness
□☐ Palpitations

Lungs / Respiratory
□☐ Cough
□☐ Shortness of Breath
□☐ Coughing up Blood
□☐ Wheezing

Stomach / Gastrointestinal
□☐ Heartburn / Reflux
□☐ Stomach Pain

Urinary
□☐ Painful Urination
□☐ Frequent Urination

Musculoskeletal
□☐ Joint Pain/Aches
□☐ Muscle Pain/Aches

Skin
□☐ Itching
□☐ Rash
□☐ Hives

Neurology
□☐ Headaches
□☐ Fainting

Blood / Glands
□☐ Easy Bruising
□☐ Bleeding Problems
□☐ Swollen Glands

Endocrine
□☐ Heat / Cold Intolerance
□☐ Sweating at Night

Psychiatric
□☐ Anxiety or Panic
□☐ Depression
New Patient Health History Form - Pediatric

**Medication List**

Please include supplements and over-the-counter medications

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dose</th>
<th>Frequency</th>
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**Medication Allergies**

Please list the name of the medication, prescription or over-the-counter, and your reaction

*(Rash, vomiting, difficulty breathing, etc.)*

<table>
<thead>
<tr>
<th>Medication</th>
<th>Reaction</th>
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<tbody>
<tr>
<td>Example: Penicillin</td>
<td>Rash</td>
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Pharmacy:_______________________
Name:_________________________
Address/Location:_____________
Phone:_______________________