SYRACUSE ENT SURGEONS

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New Patient Health History Form-Pediatric

NAME : BIRTH DATE : / /

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?_____
_____

For Women Only

☐ Are you pregnant, or is there any chance that you might be pregnant?
☐ Are you nursing?

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_____)

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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

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Medication List

Please include supplements and over-the-counter medications

Medication:	**Dose:**	**Frequency:**

Medication Allergies

Please list the name of the medication, prescription or over-the-counter, and your reaction (Rash, vomiting, difficulty breathing ,etc.)

Medication:	**Reaction:**
Example: Penicillin	*Rash*

Pharmacy:_____

Name:_____

Address/Location:_____

_____

Phone:_____

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