Dubuque ENT
HEAD & NECK SURGERY

CHILD/MINOR PATIENT MEDICAL HISTORY

Appointment date: _____ Time: _____ Dr. _____
Name: _____ DOB: _____
Pharmacy/Location: _____ Email Address: _____
Insurance Name: _____ Insurance ID#: _____

Father (Full Name): _____ Mother (Full Name): _____
Birthdate: _____ SS#: _____ Birthdate: _____ SS#: _____
Address: _____ Address: _____

Phone: (H) _____ (W) _____ Phone: (H) _____ (W) _____
(Cell) _____ (Cell) _____
Employer _____ Marital Status _____ Employer _____ Marital Status _____

Child/Minor Patient Medical History

What is the main reason for today's visit? _____
How long has this been a problem? _____ Hours _____ Days _____ Weeks _____ Months _____ Years
Please list any other complaints you want to discuss today. _____

_____

Who is the child's pediatrician or family doctor? _____
Has your child ever taken antibiotics, over-the-counter meds or other medications for this problem? ☐ Yes ☐ No
If so, please list. _____
Have X-rays, CT scans, MRI scans or allergy tests been obtained for this problem? ☐ Yes ☐ No
If so, when and where were they taken? _____

Past Medical History

Was your child born full term? ☐ Yes ☐ No
Any problems with the child's growth and development? ☐ Yes ☐ No
If yes, please explain: _____

Past Surgical History

Please write down any previous surgeries and the approximate dates; if more room is needed, please attach a separate sheet. _____

_____

Does your child have any **medical problems** that require regular visits or medications? (Please check)

☐ ADD/ADHD
☐ Anemia
☐ Asthma/Reactive airway disease
☐ Bleeding problems/Bruising
☐ Cancer
☐ Leukemia/Lymphoma
☐ Ear infections
☐ Eye problems
☐ Gastrointestinal problems
☐ Heart murmur
☐ Liver/Kidney disease
☐ Diabetes
☐ Migraine headache
☐ Muscle/Bone problems
☐ Reflux/Heartburn
☐ Sinus problems
☐ Skin disease/Rash
☐ Thyroid gland problems
☐ Other: _____

List medications and doses, including aspirin, herbal medicines, over-the-counter medicines and vitamins, that you take on a regular basis. _____

_____

LIST ANY MEDICATIONS OR SUBSTANCES YOU ARE ALLERGIC TO:

Medication: _____ Reaction: _____

Medication: _____ Reaction: _____

Medication: _____ Reaction: _____

Family History **Please list any relatives that have or have had any of the following (maternal or paternal).**

Hearing loss: _____ How related: _____ Cancer: _____ How related: _____

Diabetes: _____ How related: _____ Asthma: _____ How related: _____

Heart trouble: _____ How related: _____ Allergies: _____ How related: _____

Bleeding or clotting problems: _____ How related: _____

Social History

Who lives at home with the patient? Brothers _____ Sisters _____

Does anyone in the home smoke? ☐ Yes ☐ No

Are there pets in the home? ☐ Yes ☐ No If yes, what animals? _____

Is the child in day care? ☐ Yes ☐ No School/Elem _____ Middle _____ High School _____

Review of Systems **Please check any medical problems the child is currently having.**

Body as a Whole
☐ Fatigue
☐ Fevers
☐ Weight loss
☐ Weight gain
☐ Headache
☐ Facial pain
☐ Flat spot

Ears
☐ Drainage
☐ Decreased hearing
☐ Fluid
☐ Recurrent infection
☐ Pain
☐ Speech delay
☐ Imbalance/Not walking
☐ Dizziness

Nose
☐ Drainage
☐ Stuffiness
☐ Bad smell
☐ Polyps
☐ Foreign object
☐ Bleeding
☐ Frequen colds

Neck
☐ Large glands
☐ Pain
☐ Cyst or lump
☐ Thyroid problems

Throat
☐ Drainage
☐ Pain
☐ Tonsillitis
☐ Bad breath
☐ Snoring
☐ Large tonsils
☐ Noisy breathing
☐ Throat clearing
☐ Hoarseness
☐ Cough

Allergies
☐ Sneezing
☐ Pets in home
☐ Spring allergies
☐ Summer
☐ Fall
☐ Winter
☐ Foods

Eyes
☐ Mattering
☐ Redness
☐ Dark circles

Lungs
☐ Asthma
☐ Wheezing
☐ Bronchitis

Heart
☐ Murmur
☐ Surgery
☐ Extra beats

Stomach/GI
☐ Diarrhea
☐ Constipation
☐ Cramps
☐ Heartburn
☐ Reflux

Urinary Tract
☐ Frequency
☐ Burning
☐ Stones

Muscle/Bones
☐ Joint pain
☐ Joint swelling
☐ Weakness

Skin
☐ Eczema
☐ Itching
☐ Hives
☐ Rash
☐ Moles

Neurological
☐ Seizures
☐ Numbness
☐ Paralysis
☐ Tremor

Psych
☐ Depression
☐ Anxiety
☐ Attention deficit