**Department of Otorhinolaryngology**
**Patient History and Review of Systems**

Patient Label here

| **PAST MEDICAL HISTORY (√) Check conditions you have or have had in the past.** |
|---|

| | | | | |
|---|---|---|---|---|
| □ Anemia | □ Chicken Pox | □ Herpes | □ Mumps | □ Tuberculosis |
| □ Anorexia and/or Bulimia | □ Diabetes | □ HIV Positive | □ Pneumonia | □ Typhoid Fever |
| □ Appendicitis | □ Epilepsy | □ Kidney Disease | □ Psychiatric Care | □ Ulcers |
| □ Arthritis | □ Glaucoma | □ Liver Disease | □ Rheumatic Fever | □ Vaginal Infections |
| □ Asthma | □ Goiter | □ Measles | □ Scarlet Fever | |
| □ Bleeding Disorders | □ Congenital Heart Disease | □ Migraine Headaches | □ Stroke | |
| □ Bronchitis | □ Hepatitis | □ Mononucleosis | □ Thyroid Problems | |
| □ Cancer | □ Hernia | □ Multiple Sclerosis | □ Tonsillitis | |

| **Hospitalization and/or Surgery** |
|---|

| **Reason – Procedure** | **Dates** |
|---|---|
| | |
| | |

**Have you ever had a reaction to an anesthetic?** □ **Yes** □ **No**

| **Family History** | **Father** | **Mother** | **Sibling** | **Other** |
|---|---|---|---|---|
| Bleeding disorder | | | | |
| Cancer | | | | |
| Diabetes | | | | |
| Hearing Loss | | | | |
| Thyroid Disease | | | | |
| Heart Disease | | | | |
| Stroke | | | | |

| **SOCIAL HISTORY Check (√) and/or describe.** |
|---|
| **Child lives with: □ Parent(s) □ Grandparents □ Foster Parents How many Siblings?___________________** |

**Does your child attend day care?** □ Yes □ No – If yes how many children in the class?_____________

**Does anyone in the family smoke?** □ Yes □ No – If yes, is it around the child(ren)? □ Yes □ No

**Does your child drink liquids with caffeine?** □ Yes □ No – If yes, how much daily?_________________

**Does your child have sleeping issues? Check all that apply**

□ Difficulty falling asleep □ Frequent awakenings □ Restless Sleep

□ Witness Pauses in breathing while sleeping □ Daytime drowsiness □ Snoring □ Bed Wetting

**Is your child of school age? If yes, check all that apply – Grade__________________**

□ Doing Well □ Poor School Performance □ Poor school behavior

**REVIEW OF SYSTEMS Check (√) all symptoms your child has now or has had in the past year.**

**General**
□ Chills
□ Depression
□ Fainting
□ Fatigue
□ Fever
□ Headache
□ Loss of appetite
□ Loss of Sleep
□ Nervousness
□ Numbness
□ Sweats

**Constitutional**
□ Poor Weight Gain
□ Weight Loss
□ Difficulty Feeding
□ Fever
□ Hyperactivity
□ Fatigue
□ Bedwetting

**Skin**
□ Skin Growths/Moles
□ Eczema
□ Other rashes
□ Very dry skin
□ Skin abnormalities

**Ears**
□ Ear pain
□ Ear Infections
□ Ear Drainage
□ Hearing Change/Loss
□ Speech Delay
□ Balance Problems

**Allergy**
□ Environmental Allergies
□ Food Allergies
□ Respiratory Problems
□ Asthma
□ Noisy Breathing
□ Reactive Airway Disease
□ Shortness of Breath
□ Wheezing

**Endocrine**
□ Excessive Thirst
□ Heat/Cold Intolerance

**Hematology**
□ Bruise easily
□ Excessive bleeding
□ Anemia

**Nose**
□ Runny Nose
□ Stuffiness
□ Bloody Nose
□ Altered Sense of Smell
□ Snoring
□ Mouth breathing
□ Daytime sleepiness

**Respiratory**
□ Asthma
□ Noisy Breathing
□ Reactive Airway Disease
□ Shortness of Breath
□ Wheezing

**Eyes**
□ Wear Glasses
□ Infections

**Neurologic**
□ Headache
□ Develomental Delay
□ Poor Motor Skills

**Psych**
□ Depression
□ Panic Attacks

**Throat**
□ Sore Throat
□ Hoarseness
□ Chronic Cough
□ Difficulty Swallowing
□ Voice Change Problems
□ Recurrent Infections

**Cardiac**
□ Congenital Heart Abnormality
□ Heart Murmur

**GI**
□ Diarrhea
□ Constipation
□ Vomiting
□ Recurrent Spitting Up
□ Frequent Re-swallowing
□ Gastronomy Tube

**GU**
□ Urinary Tract Infections
□ Other Abnormalities

**Musculoskeletal**
□ Poor Control of Arms/legs
□ Developmental Delays

List all Current Medication:
____________________________________________________________________________________________
________________________________________________________________________

I hereby certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

_______________________________ _________________________________

Patient or Guardian Signature Date

_______________________________ _________________________________

Reviewed by Date

_______________________________ _________________________________

Reviewed by Physician Date