Date: _____

CHARLOTTE EYE EAR NOSE & THROAT ASSOCIATES, P.A.

PEDIATRIC MEDICAL HISTORY QUESTIONNAIRE

Please complete both sides of this form so we are able to provide you and your child with the best of care

Patient Name: _____ DOB: / / Age: _____
Please Print Last First
Gender: □ Male □ Female

Chief Complaint: _____

Patient Accompanied By: □ Mother □ Father □ Guardian □ Other: _____

PHARMACY INFORMATION: Name: _____ Phone: _____
Address: _____

Primary Care Provider: _____ Doctor who sent you here: _____

PAST MEDICAL HISTORY

□ ADD
□ ADHD
□ Anxiety
□ Asthma
□ Birth Weight
_____ lbs _____ oz
□ Bleeding Disorder
□ Depression
□ Development Delay
% on Growth Chart: _____
□ Diabetes, Type I
□ Ear Infections
□ Environmental Allergies
□ Failure to Thrive
□ Gastric Reflux
□ Hearing Loss
□ Heart Disease
□ HIV
□ Premature at Birth
Weeks of Gestation: _____
□ RSV Age: _____
□ Sinusitis
□ Sleep Apnea
□ Snoring
□ Speech Delay
□ Strep Throat
□ Tonsillitis

□ No Pertinent History □ Other History: _____

PAST SURGICAL HISTORY

Please include dates of surgery

□ Ear Surgery _____ □ Nasal/Sinus Surgery _____ □ Tonsillectomy/Adenoidectomy _____

□ Other History: _____

MEDICATION HISTORY

List current medications and dosage: _____

_____

_____

DRUG ALLERGIES

Drug Allergies: □ No Known Drug Allergies □ Yes (if yes, please list and include reaction)

_____

FAMILY MEDICAL HISTORY

□ Allergies
□ Anesthesia Problems
□ Asthma
□ Bleeding Disorder
□ Cancer
Type: _____
□ Ear Infections
□ Hearing Loss
□ Heart Disease
□ Neurological Problems
□ Thyroid Disease

□ Family History Unknown □ Other History: _____

(To complete, see reverse side)

CHARLOTTE EYE EAR NOSE & THROAT ASSOCIATES, P.A.

SOCIAL HISTORY

Tobacco Usage

□ Currently Every Day
Amount: _____ Type: _____
□ Currently Some Days
Amount: _____ Type: _____
□ Former Age Quit: _____
□ Never

□ Alcohol Usage During Pregnancy
□ Daycare/Preschool Class size: _____
□ Drug Usage During Pregnancy
□ Grade in School: _____
Name of School: _____

Other

□ Loss of School Time in Past Year
How Much? _____
□ Pacifier Use
□ Secondhand Smoke Exposure
□ Siblings How Many? _____

REVIEW OF SYSTEMS

Please check all symptoms which you have presently or have had recently. If you have not experienced a medical problem under the symptom listed, check the No box.

CONSTITUTIONAL SYMPTOMS

□ fatigue □ fever □ difficulty sleeping

Other: _____

□ No Constitutional Symptoms

EYE SYMPTOMS

□ eye discomfort □ changes in vision

Other: _____

□ No Eye Symptoms

CARDIOVASCULAR SYMPTOMS

□ chest pain □ irregular heart beats
□ lightheadedness
Other: _____

□ No Cardiovascular Symptoms

RESPIRATORY SYMPTOMS

□ shortness of breath □ hoarseness □ cough
□ wheezing
Other: _____

□ No Respiratory Symptoms

GASTROINTESTINAL SYMPTOMS

□ nausea □ heartburn □ difficulty swallowing
□ choking on liquids □ reflux
Other: _____

□ No Gastrointestinal Symptoms

GENITOURINARY SYMPTOMS

□ urgency □ pain or burning with urination
□ urinary tract infection □ kidney stones
Other: _____

□ No Genitourinary Symptoms

INTEGUMENT (SKIN) SYMPTOMS

□ new skin lesions □ lumps □ change in mole appearance
Other: _____

□ No Integument (skin) Symptoms

NEUROLOGIC SYMPTOMS

□ speech difficulties □ migraines □ dizziness □ headaches
□ seizures □ numbness/tingling □ weakness
Other: _____

□ No Neurologic Symptoms

MUSCULOSKELETAL SYMPTOMS

□ muscular weakness □ twitching □ gait changes
□ joint pain
Other: _____

□ No Musculoskeletal Symptoms

ENDOCRINE SYMPTOMS

□ weight gain □ weight loss □ history of thyroid problems
□ hot or cold intolerances
Other: _____

□ No Endocrine Symptoms

PSYCHIATRIC SYMPTOMS

□ anxiety □ depression

Other: _____

□ No Psychiatric Symptoms

HEME(BLOOD)-LYMPH SYMPTOMS

□ swollen lymph nodes □ easy bleeding or bruising

Other: _____

□ No Heme(blood)-Lymph Symptoms

ALLERGIC-IMMUNOLOGIC SYMPTOMS

□ environmental allergies □ immune deficiency

Other: _____

□ No Allergic-Immunological Symptoms