PEDIATRIC OTOLARYNGOLOGY

PATIENT HEALTH HISTORY FORM

Patient Name: ____________________DOB: ___________Date of Visit: ______
Chief Complaint:
____
____

Primary Doctor: _________________ Referring Doctor: _____________

IMMUNIZATIONS UP TO DATE? Yes or No

MEDICAL HISTORY (please include any current or past medical problems and hospitalizations)
____
____
____
____

Respiratory (asthma/wheezing/difficulty breathing) Yes or No ________________________
Constitutional (weight gain/developmental milestones) Yes or No _________________________
Neurologic (speech/language/swallow/seizures) ___________________________
Heart (chest pain/blue spells) ____
Skin ____
Muscles/bones ____
Bleeding problems _____________________________________
GI problems (constipation/diarrhea) ________________________
GU problems (urination/bladder/kidney) _____________________
Behavioral ____
Endocrine (thyroid/hormone) ______________________________
Vision ____

SURGICAL HISTORY:
____
____
____

FAMILY MEDICAL HISTORY: _____________________________________
(What illnesses run in your family) ___________________________________
Family history of bleeding disorder Yes or No
Family history of reaction to anesthesia Yes or No

SOCIAL HISTORY:
Who lives at home with the patient? _____________________________________
Does anyone smoke in or outside the home? ______________
Are there any pets at home? __________
Is the patient in Daycare? Yes or No If yes with how many other children? __________

Patient Signature: ___________________________ Date: ___________

Confirmed by:
Physician Signature: _________________________ Date: ___________