ENT FACULTY PRACTICE
PEDIATRIC PATIENT QUESTIONNAIRE

Dear Patient/Parent,

Please answer the following medical questions. ***Please be reassured that patient privacy is a top priority!***

Patient Name: ____________________Date of Birth________ Today's Date: ______________

MEDICAL HISTORY

What is the reason for your child's visit? ____

Medication and food allergies and the reactions that occur_____________________________________

Does your child have environmental allergies, if yes specify:_____________________________________

☐ **Check Here, If No Known Food Allergies** ☐ **Check Here, If No Known Environmental Allergies**

Has your child ever been diagnosed or treated for **any of these medical problems** (please check all that apply)?

☐ **Check Here, If No Past Medical Problems.**

EAR/NOSE/THROAT:			
	☐ Asthma	☐ Hearing Loss	☐ Sinus Infections
	☐ Cough	☐ Nasal Injury	☐ Seasonal Allergies
	☐ Ear Fluid/Ear Infections	☐ Neck Mass	☐ Snoring
	☐ Headache	☐ Nose Bleeds	☐ Speech Problems
	☐ Nasal Congestion	☐ Swallowing Problems	☐ Strep Throat
		☐ Voice Problems	☐ Throat clearing
			☐ Tracheostomy Care

SIGNIFICANT MEDICAL PROBLEMS NOT LISTED ABOVE:

___________________________/__________________________________/_____________________________

☐ **Check Here, If No Past Surgical Procedures.**

Surgery:			
	☐ Airway Surgery	☐ Neck Surgery	☐ Tonsillectomy or Adenoidectomy
	☐ Ear Surgery	☐ Palate Surgery	☐ Tracheostomy
	☐ Frenuloplasy (Tongue Tie)	☐ Sinus Surgery	

SIGNIFICANT SURGICAL PROCEDURES NOT LISTED ABOVE:

___________________________/__________________________________/_____________________________

Name: ________________________ **Date of Birth** _______

Medications: List medications, vitamins and supplements taken by your child.
Medication:_________________________ Dosage(if known):____
Medication:_________________________ Dosage(if known):____
Medication:_________________________ Dosage(if known):____
Medication:_________________________ Dosage(if known):____

Family Medical History: Has any member of the patient's family experienced problems with any of the following?
If so, please specify who (relation to the patient) and explain the problem:

Bleeding Problems:____

Anesthesia Problems:____

Ear/Nose/Throat Issues:____

Genetic/Chromosome Issues: ____

Hearing Issues: ____

"**Review of Systems**": **Check off box if your child *currently* has these medical issues:**

Constitutional: ☐ **No Problems** _☐ Weight gain/loss ☐ Fever/night sweats ☐ Fatigue/loss of energy
Other:____

Heart: ☐ **No Problems** ☐ Irregular heart beat ☐ Chest pain ☐ Lightheadedness
Other:____

Respiratory & Lungs: ☐ **No Problems** ☐ Wheezing ☐ Asthma ☐Bronchiolitis ☐ Coughing ☐ Recurrent croup ☐ Recurrent pneumonia
Other:____

Head & Neck: ☐ **No Problems** ☐ Headaches/Migraines ☐ Enlarged lymph nodes ☐ Other neck masses
Other:____

Gastrointestinal: ☐ **No Problems** ☐ Feeding Difficulties or Reflux ☐ Nausea/vomiting ☐ Constipation or diarrhea
Other:____

Genitourinary: ☐ **No Problems** ☐ Pain with urinating ☐ Blood in urine ☐ Groin pain
Other:____

Endocrine: ☐ **No Problems** ☐ Heat/cold intolerance ☐ Excessive thirst/appetite ☐ Excessive hair growth
Other:____

Hematologic: ☐ **No Problems** ☐ Abnormal bleeding/bruising ☐ Loss of energy ☐ Exposure to mono/ticks
Other:____

Musculoskeletal: ☐ **No Problems** ☐ Joint pain/swelling ☐ Muscle pain/weakness ☐ Scoliosis
Other:____

Neuropsychiatric: ☐ **No Problems** ☐ Attention deficit ☐ Mood swings/depression ☐ Seizures
Other:____

Allergy and Immunology: ☐ **No Problems** ☐ Immune deficiency ☐ HIV/AIDS ☐ Environmental allergies
Other:____

Congenital Anomalies & Genetic Problems: ☐ **No Problems** ☐ Syndrome/ Abnormal Facial Development ☐ Cleft lip or palate ☐ Craniofacial abormality
Other:____
Signature: ____