|  |
| --- |
| Place label here |

Pediatric ENT

 Patient Medical History Form

Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please fill out the following tables to ensure we have up to date information.

**Medical History**

**Please circle Yes or No**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Runny Nose | Yes | No | Choanal Atresia | Yes  | No | Cleft Lip | Yes | No |
| Cleft Palate | Yes | No | Cystic Fibrosis | Yes | No | Difficulty Swallowing | Yes | No |
| Epiglottitis | Yes | No | Headaches | Yes | No | Hearing Loss | Yes | No |
| Hoarseness | Yes | No | Swollen Lymph Nodes | Yes | No | Nasal Fracture | Yes | No |
| Nasal Polyps | Yes | No | Nosebleeds | Yes | No | Ear Infections | Yes | No |
| Recurrent URI | Yes | No | Shortness of Breath | Yes | No | Sinus Disease | Yes | No |
| Sleep Apnea-Central | Yes | No | Strep Throat (Recurrent) | Yes | No | Stridor/Noisy Breathing | Yes | No |
| Thyroid Disease | Yes | No | Ringing in the Ears | Yes | No | TMJ Problem | Yes | No |

If you answer yes to any of the above please list the illness and date of diagnosis:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Pre-Operative Screening**

**Please circle Yes or No**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Abnormal ECG | Yes | No | Coronary Artery Disease | Yes | No | Liver Disease | Yes | No |
| Alcoholism | Yes | No | Deep Vein Thrombosis | Yes | No | Myocardial Infarction | Yes | No |
| Anemia | Yes | No | Diabetes Mellitus | Yes | No | Pulmonary Arterial Hypertension | Yes  | No |
| Anesthetic Complications | Yes | No | Hepatitis | Yes | No |
| Asthma | Yes | No | History of Blood Transfusion | Yes | No | Seizures | Yes  | No |
| CHF | Yes | No | HIV/AIDS | Yes | No | Sickle Cell Anemia | Yes | No |
| Cirrhosis | Yes | No | High Blood Pressure | Yes | No | Stroke | Yes  | No |
| Clotting Disorder | Yes | No | Kidney Disease | Yes | No | Substance Abuse | Yes | No |
| COPD | Yes | No | Cancer | Yes | No | TIA/Mini Strokes | Yes | No |

If you answer yes to any of the above please list the illness and date of diagnosis:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Surgical History**

**Please circle Yes or No**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Adenoidectomy | Yes | No | Airway Repair | Yes | No | Eye Surgery | Yes | No |
| Nasal Polypectomy | Yes  | No | Parathyroid Surgery | Yes | No | Sinus Surgery | Yes | No |
| Thyroid Surgery | Yes | No | Tonsillectomy | Yes | No | Tracheostomy | Yes | No |
| Ear Tubes | Yes | No |  |  |  |  |  |  |

If you answered yes to any of the above please list the date of surgery:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Family History**

**Please put a check mark in the columns below where it applies.**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Family Member** | **Asthma** | **Cancer** | **Diabetes** | **Ear Infections** | **Heart Failure** | **Hyperlipidemia** | **Hypertension** | **Migraines** | **Osteoarthritis** | **Rashes** | **Thyroid Disease** | **Seizures** | **Stroke** |
| **Mother** |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Father** |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Sister** |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Brother** |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Aunt –** **Mom’s side** |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Uncle –** **Mom’s side** |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Aunt –** **Dad’s side** |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Uncle –** **Dad’s side** |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Grandmother – Mom’s side** |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Grandfather – Mom’s side** |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Grandmother – Dad’s side** |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Grandfather – Dad’s side**  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Other** |  |  |  |  |  |  |  |  |  |  |  |  |  |

**Tobacco Smoke History – does anyone smoke in household? Please circle Yes or No**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Father | Yes | No | Mother | Yes | No | Grandmother | Yes | No |
| Grandfather | Yes | No | Guardian | Yes | No | Anyone else | Yes | No |

The patient is exposed to secondhand smoke ……(please circle the correct response):

DAILY SEVERAL TIMES PER WEEK SEVERAL TIMES PER MONTH NEVER

Person Completing this Form:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Patient\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_