Please answer this questionnaire to the best of your knowledge. Information is confidential and will be used by the care providers of Renew ENT & Hearing Center to evaluate and treat your medical problems.

RENEW ENT & HEARING CENTER

Pediatric Medical History Form

Please print (if you do not understand a question, leave it blank)

Today's date _____

PATIENT NAME _____
(First) (M) (Last) (Date of birth)

Name of your child's pediatrician or family doctor: _____ Clinic: _____

Is your child in good health? No____ Yes____ If no, please explain: _____

_____

Does your child have any current or past medical problems? (e.g. heart, lung, urinary tract, blood, immune system, etc.) No____ Yes ____

If yes, please explain: _____

_____

Does your child have a specific named syndrome? No____ Yes____ If yes, please list: _____

Was there a problem during your child's pregnancy, labor and/or delivery? No____ Yes____ If yes, please explain: _____

_____

Child's height: _____ Child's weight: _____

Previous hospitalization(s)? No ____ Yes____ If yes, please list: _____

Previous surgery? No____ Yes ____ If yes, please list: _____

Current medications: No ____ Yes ____ Please list: _____

Allergies: Medications? No ____ Yes____ Please list: _____

Hay fever, dust, etc.? No ____ Yes____ Please list: _____

Foods? No____ Yes____ Please list: _____

Does your child have problems with excessive bleeding or easy bruising? No____ Yes ____ If yes, please explain: _____

_____

Is there a family history of unusual or severe diseases or bleeding problems? No____ Yes____ If yes, please explain: _____

_____

Is your child in daycare? No ____ Yes ____ If yes, your child is in daycare with (please check one) ☐ More than 10 children ☐ Less than 10 children

Are there any pets in the home? No____ Yes____ Please list: _____ Are there any smokers in the home? No____ Yes ____

If your child is older than 13 years-old, do they use tobacco? Yes____ No____ (Cigarettes_Chewing_Cigar/Pipe_Cessation in progress_)

Review of Systems: Please circle "Y" or "N" for any symptoms your child does/ does not have:

GENERAL		RESPIRATORY		GASTROINTESTINAL	
Unexplained fevers/night sweats	Y/ N	Persistent cough	Y/ N	Nausea/vomiting	Y/ N
Unintentional weight loss	Y/ N	Hoarseness	Y/ N	Heartburn/acid reflux	Y/ N
		Shortness of breath	Y/ N		
SKIN				EYES	
Change in moles	Y/ N	MUSCLE/JOINT/BONE		Blurred vision	Y/ N
Sore that won't heal	Y/ N	Pain, weakness or numbness in:		Double vision	Y/ N
		Arms/legs	Y/ N		
ENT		Back/neck	Y/ N	HEME/LYMPH	
Difficulty swallowing	Y/ N	NEUROLOGIC		Enlarged lymph nodes	Y/ N
Ear pain/drainage	Y/ N	Headache	Y/ N	Excessive bleeding	Y/ N
Hearing loss	Y/ N	Numbness/tingling	Y/ N		
Nosebleeds	Y/ N			CARDIOVASCULAR	
Ringing in ears	Y/ N	ALLERGY/IMMUNOLOGY		Chest pain	Y/ N
Sinus problems	Y/ N	Decreased immunity	Y/ N	Irregular heartbeat	Y/ N
		Hay fever	Y/ N	Heart murmur	Y/ N

Is there any other information you would like to share about your child? No____ Yes____ If yes, please explain: _____

_____

_____

Physician use only: Date/Initials _____