DIVISION OF OTOLARYNGOLOGY - NEW PATIENT HISTORY QUESTIONNAIRE

Patient Name: __________________________ Patient Nickname: __________________________ Date of Birth: __________________________

Pediatrician: __________________________ Referring Physician: __________________________

Medication Allergies: Y  N (If Y, please list along with the type of reaction)

In daycare or school? Y  N How is school performance (check one)? Good _______ Fair _______ Poor _______

Reason for today’s visit: (Check all that apply and fill out additional questions if pertinent)

- **Ear Infections (Otitis Media):** If so please fill out # 1-6
  1. Age at 1st ear infection: _____ # in the past 6 months: _____ # in the past 12 months: _______
  2. How have they been treated? (If antibiotics, which ones?)
  3. How do you know your child has an ear infection?

  4. Does your child:
     a. Have a runny nose Y  N
     b. Have a stuffy nose Y  N
     c. Snore Y  N
     d. Go to daycare Y  N
     e. Have exposure to second hand smoke Y  N
     f. Live with dogs or cats in the house Y  N
     g. Have siblings who’ve had ear infections Y  N -> Did they get PE tube Y  N

- **Fluid in the ear(s):** When last clear of middle ear fluid?

- **Difficulty sleeping at night: If so please fill out # 1-14**
  1. Snoring: Y  N
     a. Is it every night? Y  N
     b. In all positions Y  N
     c. How long have you noticed this? _______
     d. How loud (on a scale of 1-10 with 10 being the loudest)?
  2. Breathing pauses while asleep Y  N
  3. Bedwetting Y  N
  4. Mouth Breathing Y  N
  5. Night terrors Y  N
  6. Sleepwalking/Sleeptalking Y  N
  7. Difficulty swallowing Y  N -> (If Y, describe)
  8. Food/drinks leak out of nose Y  N -> (If Y, liquids or solids)
  9. Do you consider your child (check one) overweight? ______ underweight? ______ normal weight? ______

- **Head/Neck mass:**
- **Hearing loss:** How long?
- **Speech delay or disturbance:**
- **Balance issues:**
- **Feeding issues:**
- **Nosebleeds:**
- **Nasal Congestion:**
- **Noisy Breathing:**
- **Voice concern:**
- **Sinus Infections:** 1. # of times in the last 6 months? _______
  2. Usual # of days with symptoms prior to starting antibiotics: _______
- **Recurrent croup:**
- **Recurrent sore throats, tonsillitis, or strep throat:**
  1. # of episodes of strep in the past year: _____ # the year prior______ # the year prior to that ______
  2. # of days of school missed this year due to sore throats ______
- **Other:**
## MEDICAL HISTORY:

**Patient History:**

<table>
<thead>
<tr>
<th>Was your child born prematurely?</th>
<th>Y</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prior Surgeries: (List)</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Problems with Anesthesia?</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Prior hospitalizations: (List)</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Are you aware of any present infectious disease? (List)</td>
<td>Y</td>
<td>N</td>
</tr>
</tbody>
</table>

**Does your child now or has he/she had any recent problems related to the following systems?**

<table>
<thead>
<tr>
<th>Bladder</th>
<th>Y</th>
<th>N</th>
<th>Bleeding</th>
<th>Y</th>
<th>N</th>
<th>Eyes</th>
<th>Y</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Problems with urination</td>
<td>Y</td>
<td>N</td>
<td>Clotting problems</td>
<td>Y</td>
<td>N</td>
<td>Blurred vision</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Other:</td>
<td></td>
<td></td>
<td>Easy bruising</td>
<td>Y</td>
<td>N</td>
<td>Pain</td>
<td>Y</td>
<td>N</td>
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<td></td>
<td></td>
<td></td>
<td>Other:</td>
<td></td>
<td></td>
<td>Other:</td>
<td></td>
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<tr>
<td>Heart</td>
<td>Y</td>
<td>N</td>
<td>Hormones</td>
<td>Y</td>
<td>N</td>
<td>Lungs</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Heart murmur</td>
<td>Y</td>
<td>N</td>
<td>Diabetes</td>
<td>Y</td>
<td>N</td>
<td>Asthma</td>
<td>Y</td>
<td>N</td>
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<tr>
<td>High blood pressure</td>
<td>Y</td>
<td>N</td>
<td>Thyroid condition</td>
<td>Y</td>
<td>N</td>
<td>Noisy breathing</td>
<td>Y</td>
<td>N</td>
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<tr>
<td>Other:</td>
<td></td>
<td></td>
<td>Excessive thirst</td>
<td>Y</td>
<td>N</td>
<td>Frequent coughs</td>
<td>Y</td>
<td>N</td>
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<td></td>
<td></td>
<td></td>
<td>Other:</td>
<td></td>
<td></td>
<td>Other:</td>
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<tr>
<td>Musculoskeletal System</td>
<td>Y</td>
<td>N</td>
<td>Nervous system</td>
<td>Y</td>
<td>N</td>
<td>Skin</td>
<td>Y</td>
<td>N</td>
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<tr>
<td>Joint pain</td>
<td>Y</td>
<td>N</td>
<td>Seizures</td>
<td>Y</td>
<td>N</td>
<td>Rash</td>
<td>Y</td>
<td>N</td>
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<tr>
<td>Back pain</td>
<td>Y</td>
<td>N</td>
<td>VP shunt</td>
<td>Y</td>
<td>N</td>
<td>Abnormal birth marks</td>
<td>Y</td>
<td>N</td>
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<tr>
<td>Other:</td>
<td></td>
<td></td>
<td>Abnormal coordination</td>
<td>Y</td>
<td>N</td>
<td>Itching</td>
<td>Y</td>
<td>N</td>
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<td></td>
<td></td>
<td></td>
<td>Other:</td>
<td></td>
<td></td>
<td>Other:</td>
<td></td>
<td></td>
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<tr>
<td>Stomach/Intestines</td>
<td>Y</td>
<td>N</td>
<td>General</td>
<td>Y</td>
<td>N</td>
<td>Additional medical history/diagnoses/syndromes: (please describe)</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Stomach pain</td>
<td>Y</td>
<td>N</td>
<td>Fever/chills</td>
<td>Y</td>
<td>N</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Nausea/Vomiting</td>
<td>Y</td>
<td>N</td>
<td>Abnormal development</td>
<td>Y</td>
<td>N</td>
<td></td>
<td></td>
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<tr>
<td>Problems with stool</td>
<td>Y</td>
<td>N</td>
<td>Psycho/social concerns</td>
<td>Y</td>
<td>N</td>
<td></td>
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<tr>
<td>Other:</td>
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<td>Other:</td>
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</table>

**Family history** of any Ear/Nose/Throat or Head and Neck problems? (please describe)

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The above information is accurate to the best of my knowledge.

X ____________________________

Signature of parent or guardian: ____________________________

Date & Time: ____________________________

**Relationship to patient**

FOR PHYSICIAN USE ONLY:

I have reviewed the above information with the patient/parent.

Physician name & signature: ____________________________

Pager: ____________________________

Date & Time: ____________________________

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