Ann & Robert H. Lurie Children's Hospital of Chicago™

3469P

Medical Record No.
Patient Name
Birthdate
Physician

Chicago, IL 60661

Please align patient label to the right

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)

Lives with Mom/Dad/Other _____
Grade of school _____
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 ear tubes Y N

5. Was your child born full-term? Y N
6. Did your child:
   - a. Pass the newborn hearing test? Y N
   - b. Receive breast milk after birth? Y N
   - c. Receive all his/her immunizations? 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? _____
10. Frequent waking at night Y N
11. Restless sleep (moving around in bed) Y N
12. Difficulty waking in the morning Y N
13. Excessive daytime tiredness Y N
14. Behavior issues Y N

☐ **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:

Was your child born prematurely?	Y	N
Prior Surgeries: (List)	Y	N
Problems with Anesthesia?	Y	N
Prior hospitalizations: (List)	Y	N
Are you aware of any present infectious disease? (List)	Y	N

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

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

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

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