Northland Ear, Nose & Throat, P.C.
Pediatric Medical History Form
www.northlandent.com

_____
Today's Date

Legal Name: _____ Current Age: _____ Date of Birth: _____
☐ Male ☐ Female Height : _____ Weight: _____
Family Physician: _____ Referring Physician: _____

Reason for being seen today (Please list your symptoms): _____
_____
_____
Onset of symptoms: _____

How severe are your symptoms at this time:
- ☐ No longer present
- ☐ Mild
- ☐ Moderate
- ☐ Severe
- ☐ Disabling

List the medications used to treat your symptoms:
(Include non-prescriptions)
_____
_____
_____
_____

Current Medications (Including Non-Prescriptions):

Medication:	Dose:	How often do you take the medication?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

List the medications that your child has had **within the last six months**:

_____	_____	_____
_____	_____	_____
_____	_____	_____

Past Medical History:
Do you have a history of

☐	Heart Disease	☐	Pneumonia		
☐	Rheumatic fever	☐	Bronchitis		
☐	Heart rhythm problems	☐	Kidney disease		
☐	Anemia (low red blood cell count)	☐	Other urinary tract disease		
☐	Bleeding disorders	☐	Hepatitis or liver disease		
☐	Frequent ear infections	☐	AIDS or HIV positive status		
☐	Hearing loss	☐	Spine problems		
☐	Frequent sore throat	☐	Diabetes	☐	Neurological problems
☐	Asthma	☐	Cancer	☐	Other major illnesses (list)

Comments: _____
_____

Past Surgeries or Trauma History:
Please mark any prior surgeries and the date completed next to it.

☐	Tonsillectomy/Adenoidectomy	☐	Hernia repairs
☐	Ear or mastoid surgery	☐	Pyloromyotomy
☐	Placement of ear tubes	☐	Appendectomy
☐	Removal of lymph nodes from neck	☐	Repair of fractures
☐	Thyroid gland surgery	☐	Anesthesia difficulties
☐	Other head or neck surgery	☐	Spine surgery
☐	Heart surgery	☐	Excessive bleeding

☐ Other (please list) _____
_____

CONTINUED ON BACK SIDE

Family Medical History:
Is there a family history of heart disease, stroke, cancer, hearing loss, diabetes, thyroid, etc? Please list details:
_____
_____
_____

Social/Psycho-Social History:
□ Daycare □ Second-hand smoke exposure □ Family unit support □ Child copes well

Allergy History/Drug Allergies:
Additionally, please list if there are any smokers in the household or pets living with your child.
_____
_____
_____

Immunizations:
Is your child up to date on his or her immunizations? □ yes □ no

Systems Review:
Please check all that apply to your child:
Sleep: □ none □ loud snoring □ excessive daytime sleep □ trouble going to sleep □ trouble staying asleep

Constitutional: □ fever □ chills □ excessive weight loss or gain □ fatigue

Eyes: □ vision loss □ double vision □ tearing eyes □ worsening vision

Cardiovascular: □ palpitations □ racing heart □ chest pains □ cold/swollen extremities

Respiratory: □ wheezing □ dry cough □ productive cough □ night sweats □ shortness of breath

Gastrointestinal: □ increased/decreased appetite □ nausea □ vomiting □ abdominal pain □ diarrhea/constipation

Musculoskeletal: □ joint pain □ swelling □ stiffness □ muscle weakness

Integumentary: □ changes in skin lesion

Psychiatric: □ irritability □ depression □ anxiety □ insomnia □ drug or alcohol addiction (past or present)

Neurological: □ loss of smell or taste □ facial weakness or numbness □ memory problems □ headaches (how often)
□ difficulty walking □ difficulty swallowing/speaking

Endocrine: □ increase in size of hands/feet □ heat/cold intolerance □ excessive thirst □ thyroid problems

Hematologic/Lymphatic: □ swollen nodes □ excessive bruising or bleeding

Allergic/Immunologic: □ allergy to medicines □ seasonal allergies

Additional: _____
_____

_____ _____
Signature **Date**

_____
Relationship to the Child