NorthShore University HealthSystem

Division of Otolaryngology-
Head and Neck Surgery

Main Phone: 847 504-3300
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PEDIATRIC MEDICAL HISTORY QUESTIONNAIRE

Date of appointment: ___________

Patient Name: ____________________________ Nickname: _________________ Date of Birth: __________
(Last, First, MI)
Referring Physician: ___________________________ Primary Care Provider: _________________

Medication Allergies: Yes / No If Yes, to what and explain reaction: ______________________
Current Medications with dosage ____
____

Immunizations up to date? Yes / No If not, what is missing? ________________________
Reason for today's visit: ____
____

Ear, Nose, and Throat

Recurrent Ear Infections Yes No
Age at 1st infection: _____ # in the past 6 months: _____

Hearing loss	Yes	No	Nosebleeds	Yes	No
Balance disturbance	Yes	No	Nasal congestion/Mouth breathing	Yes	No
Speech development delay	Yes	No	Headache	Yes	No
Difficulty feeding	Yes	No	Head, face or neck swelling	Yes	No
Voice concerns	Yes	No	Shortness of breath	Yes	No
Noisy breathing	Yes	No	Cough	Yes	No

Recurrent sinus infections Yes No
in the past 12 months: _____ # days with symptoms before treating :

Recurrent tonsillitis: Yes No # this year: _____ # last year: _____ # year before:

Difficulty sleeping at night	Yes	No	Bedwetting:	Yes	No
Snoring:	Yes	No	Pauses in breathing:	Yes	No
Night terrors, sleep walking:	Yes	No	Excessive daytime tiredness:	Yes	No
Behavior issues, hyperactivity:	Yes	No	Frequent waking at night:	Yes	No
Difficulty chewing/swallowing:	Yes	No	Restless sleep:	Yes	No
Does food/liquid leak from nose:	Yes	No	Difficulty waking in morning	Yes	No

Prior major illnesses/injuries, diagnoses, and syndromes:
____
____

Birth History:

Was your child born premature?	Yes	No	Number weeks gestation: _______________		
Any problems with/after delivery?	Yes	No	Was your child on a ventilator?	Yes	No
Was your child jaundiced?	Yes	No	If yes, Transfusion used	Yes	No

Prior Hospitalizations: list age(s) and reason ____
Prior Surgeries: list including age at time of procedure: ______________________________

Review of Systems:

Allergic/Immunologic:
Environmental allergy symptoms Yes No
Perennial (year round) Yes No
Seasonal symptoms Yes No
Which Season(s)____________________
Food allergies Yes No
List: ___________________________
Immunologic disorder Yes No
List: __________________________
Previous allergy testing Yes No
At what age: ____________________
Allergist: ____
List positive reactions: ___________________________

Gastrointestinal:
Gastroesophageal reflux as infant: Yes No
Age at diagnosis ______________________
Diagnostic tests used ______________________
Treatment given ______________________
Current reflux symptoms/concerns: Yes No
Current reflux treatment: Yes No
Recurrent spitting up/ vomiting: Yes No
Frequent reswallowing Yes No
Irritability after feedings Yes No
Chronic constipation Yes No
Recent change in Bowel Habits Yes No

Respiratory:
Asthma/ reactive airway disease Yes No
Recurrent bronchitis Yes No
Recurrent pneumonias Yes No
Other Yes No

Endocrine:
Diabetes Yes No
Thyroid abnormalities Yes No
Other hormonal abnormalities Yes No

Bleeding Disorders:
More bleeding than expected at umbilical cord, circumcision or other surgery, injury, or loss of teeth): Yes No
Bruising more easily than normal: Yes No
In older girls, heavy menstrual periods: Yes No
Any blood relatives with an inherited bleeding problem such as Hemophilia, von Willebrand, or low platelets? Yes No
Any blood relatives called free bleeders: Yes No

Cardiovascular:
Congenital heart abnormality Yes No
Heart murmur Yes No

Hematologic/ Lymphatic
Anemia Yes No
Persistent swollen lymph nodes Yes No
Other Yes No

Integumentary:
Eczema, rashes Yes No
Abnormal birth marks Yes No
Other skin abnormalities Yes No

Eyes:
Blurred or double vision Yes No
Pain, swelling or other Yes No

Genitourinary:
Problems with urination Yes No
Other abnormalities Yes No

Psychiatric
Depression Yes No
Attention Deficit Yes No
Behavioral Problem Yes No
Other psychiatric abnormalities Yes No

***Family History**:*
Is your child Adopted? Yes No
Are there any family members with:
Cleft lip/palate or other craniofacial abnormalities: Yes No _______________
Childhood onset hearing loss not associated with ear infections: Yes No _______________
Allergy or Immune disorders: Yes No _______________
Malignant Hyperthermia: Yes No _______________
Other problems with anesthesia: Yes No _______________
Other ENT/head and neck issues: Yes No _______________

Social History
Your child lives at home with :
Mother Yes No Siblings: _____ # Brothers
Father Yes No Siblings: _____ # Sisters
Others: ________ Pets: Yes No ___________
Does anyone smoke at home? Yes No
Is your child in Daycare Yes No
Is your child in school? Yes No
What grade?_____________________________

In the past month:
Travel outside of Area Yes No
Location(s): ____________________________________
Travel outside of US Yes No
Location(s): ____________________________________

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

X ________________________________ _______ ____________________

Signature of Parent or Guardian Date Relationship to Patient