NorthShore
University HealthSystem

Division of Otolaryngology

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Date: _____

New Pediatric Patient Questionnaire

Patient Name: _____ Nickname: _____
(Last, First, MI)

Sex: _____ Age: _____ Date of Birth: _____

Referring Physician: _____

Pediatrician: _____

Medication Allergies: Yes / No
If Yes, to what and explain reaction: _____
_____

Current Medications: _____
_____

Immunizations up to date? Yes / No If not, what is missing? _____

Reason for today's visit: _____
_____
_____

Past Medical History

Please list any prior major illnesses and/or injuries:

_____
_____
_____
_____

Birth History:

Any problems with the pregnancy? Yes No If yes, what?_____
Was you child born full term? Yes No
If no, how early?_____
Was your child on a ventilator? Yes No If yes, how long?_____
Was your child jaundiced? Yes No
If yes, was transfusion needed Yes No

Hospitalization:
Except at birth, has your child been hospitalized Yes No
If yes, list age(s) and reason _____
_____
_____

Surgery:
Has your child ever had surgery? Yes No
If yes, list age(s), and reason _____
_____
_____

Review of Systems:

Does your child have or has your child ever had (if yes, please explain):

	Circle One		If Yes, please explain
General:			
Fever	Yes	No	_____
Poor weight gain/weight loss	Yes	No	_____
Problems with nutrition	Yes	No	_____
Difficulty feeding	Yes	No	_____
Chicken pox	Yes	No	_____
Genetic disorders	Yes	No	_____
Ear, Nose, and Throat			
Ear Infections (Otitis Media)	Yes	No	_____
Age at 1st ear infection_____			
Number of infections in the past 6 months_____			
Number of courses of antibiotics in past 6 months_____			
When last clear of middle ear fluid_____			
Concern with possible hearing loss	Yes	No_____	
Concern that speech development may not be age appropriate?	Yes	No_____	
Balance disturbance	Yes	No_____	
Nosebleeds	Yes	No_____	
Nasal congestion	Yes	No_____	
Sinus infections	Yes	No:_____	
Number of sinus infections in past 6 months_____			
With each infection, usual number of days symptomatic prior to starting antibiotic therapy _____			
Recurrent tonsillitis	Yes	No_____	
Number of episodes strep (+) tonsillitis in the past year_____			
Number of episodes the year before _____, and the year before that_____			

Difficulty sleeping at night	Yes	No	_____
Snoring	Yes	No	_____
If yes: loud and obstructive	Yes	No	_____
Retractions/working to breathe	Yes	No	_____
Bedwetting	Yes	No	_____
Mouth breathing	Yes	No	_____
Excessive daytime tiredness	Yes	No	_____
Hyperactivity	Yes	No	_____
Difficulty chewing/ swallowing	Yes	No	_____
Is nasal regurgitation a problem when eating?	Yes	No	_____

Eyes:

Wear Glasses	Yes	No	Date of last exam _____
Infections	Yes	No	_____
Injuries	Yes	No	_____
Other problems	Yes	No	_____

Neurological:

Headaches	Yes	No	_____
Seizure disorder	Yes	No	_____
Developmental delay	Yes	No	_____
Poor gross motor development	Yes	No	_____
Cerebral palsy	Yes	No	_____

Cardiovascular:

Congenital heart abnormality	Yes	No	_____
Heart murmur	Yes	No	_____

Respiratory:

Asthma/ reactive airway disease	Yes	No	_____
Bronchopulmonary dysplasia	Yes	No	_____
Noisy breathing	Yes	No	_____
Shortness of breath	Yes	No	_____
Cough	Yes	No	_____
Bronchitis	Yes	No	_____
Pneumonia	Yes	No	_____

Allergic/Immunologic:

Environmental allergy	Yes	No	_____
Food allergy	Yes	No	_____
Immunologic disorder	Yes	No	_____
Previous allergy testing	Yes	No	

If yes, when_____

List any positives_____

_____

Gastrointestinal:

Gastroesophageal reflux Yes No_____
If yes, age at diagnosis _____
Diagnostic tests used _____
Treatment given _____
Recurrent spitting up/ vomiting Yes No_____
Frequent reswallowing Yes No_____
Irritability after feedings Yes No_____
Change in Bowel Habits Yes No_____

Endocrine:

Diabetes Yes No_____
Thyroid abnormalities Yes No_____
Other hormonal abnormalities Yes No_____

Bleeding Disorders:

Has your child ever had surgery, stitches for trauma or a broken bone? Yes No _____
If yes, was there more bleeding than expected during or after? Yes No _____
Does you child bruise more easily than normal Yes No _____
If a boy and circumcised, was bleeding more than expected after the circumcision Yes No _____
Was there bleeding when the umbilical cord came off? Yes No _____
Has your child had frequent nosebleeds? Yes No _____
Has your child bled more than normal after loss of baby teeth? Yes No _____
Is your child taking aspirin or ibuprofen products? Yes No _____
If an older girl, is there a history of heavy menstrual periods? Yes No _____
Has your child ever needed a blood transfusion for prolonged bleeding? Yes No _____
Do any blood relatives have an inherited bleeding problem such as Hemophilia, von Willebrand, or low platelets? Yes No _____
Has any blood relative been called a free bleeder? Yes No _____

Hematologic/ Lymphatic

Anemia Yes No_____
Persistent Swollen Glands or Lymph Nodes Yes No_____
Blood Transfusion Yes No_____
If Yes: at what age_____ and why _____

Musculoskeletal:

Broken Bones	Yes	No_____
Developmental abnormalities	Yes	No_____
Poor control of arms/legs	Yes	No_____

Genitourinary:

Urinary Tract Infections	Yes	No_____
Other abnormalities	Yes	No_____

Integumentary:

Eczema	Yes	No_____
Recurrent Rashes	Yes	No_____
Other skin abnormalities	Yes	No_____

Psychiatric

Any psychiatric abnormalities	Yes	No_____

Family History

Is your child Adopted? Yes No

If yes, please fill out what information may be known about the birth family

Are there any family members with:	Circle One		If Yes, please explain:
Cleft lip/palate or other craniofacial abnormalities	Yes	No	_____
Childhood onset hearing loss not associated with ear infections	Yes	No	_____
Immune disorders	Yes	No	_____
Malignant Hyperthermia	Yes	No	_____
Other problems with anesthesia	Yes	No	_____
Other significant illnesses in the family:	Yes	No	_____

If yes please list as follows:

Family Member	*List significant illnesses*
_____	_____
_____	_____
_____	_____

Social History

Your child lives at home with:

Mother	Yes	No	_____
Father	Yes	No	_____
Siblings	Yes	No	_____#Brothers _____#Sisters
Foster Care	Yes	No	_____
Pets	Yes	No	_____

Does anyone smoke at home? Yes No _____

Is your child in Daycare Yes No

If yes, how many days per week?_____

How many kids in your child's room? _____How many in the daycare?_____

Is your child in school? Yes No What grade?_____

Number of days per week?_____

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

X _____ _____

Signature of Parent or Guardian Date

_____

Relationship to Patient

For Physician Use Only:

Special Considerations:

Patient Education: ❍Needs Assessed, None Needed
❍See Progress Notes
❍See Sample Drug Log

Problems with ADL's and Mobility:
❍No
❍Yes Explain: _____

Nutritional Status:
❍Completed Assessment, No referral necessary.
❍Completed Assessment, Referred to Dietician

I have reviewed the above information with the patient.

_____ _____

Physician Name & Signature Date