

Division of Otolaryngology

Main Phone: 847 504-3300
Main Fax: 847 504-3305

PEDIATRIC MEDICAL HISTORY QUESTIONNAIRE

Date of appointment: _____

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

Sex: _____ Age: _____ Date of Birth: _____

Referring Physician: _____ Phone: _____

Primary Care Provider: _____ Phone: _____

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	_____
Was your child born full term?	Yes	No	Number weeks gestation: _____
Any problems with/after delivery?	Yes	No	_____
Was your child on a ventilator?	Yes	No	If yes, how long? _____
Was your child jaundiced?	Yes	No	If yes, Transfusion used 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 significant issues with any of the following (if yes, please explain):

	<u>Circle One</u>	<u>If Yes, please explain</u>
<i>General:</i>		
Unexplained Fever	Yes No	_____
Poor weight gain/weight loss	Yes No	_____
Problems with nutrition	Yes No	_____
Difficulty feeding	Yes No	_____
Genetic disorders	Yes No	_____

Ear, Nose, and Throat

Recurrent Ear Infections	Yes No	Age at 1 st infection _____
Number of ear infections in the past 6 months		_____
Number of courses of antibiotics in past 6 months		_____
Persistent middle ear fluid	Yes No	Duration present (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	_____
Recurrent Sinus infections	Yes No	
Number of sinus infections in past 12 months		_____
Usual number of days with symptoms before starting antibiotics		_____
Duration of antibiotics used to treat most infections		_____
Recurrent tonsillitis	Yes No	Number of infections in past year _____
Number of episodes strep (+) tonsillitis:		
in the past year _____; the year before _____; 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 during day	Yes	No	_____
Excessive daytime tiredness	Yes	No	_____
Hyperactivity	Yes	No	_____
Difficulty chewing/ swallowing	Yes	No	_____
Does food/liquid come out the nose when eating and/or drinking	Yes	No	_____

Eyes:

Wear Glasses	Yes	No	Date of last exam _____
Infections/injuries	Yes	No	_____
Other eye 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	_____

Musculoskeletal:

Broken Bones	Yes	No	_____
Developmental abnormalities	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 allergysymptoms	Yes	No	_____
Perennial (year round) symptoms	Yes	No	_____
Seasonal symptoms	Yes	No	Which Season(s)_____

Food allergy symptoms	Yes	No	_____
Immunologic disorder	Yes	No	_____
Previous allergy testing	Yes	No	At what age: _____
Allergist (Name/Practice/Location)	_____		
List any positive reactions:	_____		

Environment/food allergies– family member	Yes	No	_____
---	-----	----	-------

Gastrointestinal:

Gastroesophageal reflux	Yes	No	Age at diagnosis _____
Diagnostic tests used _____			
Treatment given _____			
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	_____

Cardiovascular:

Congenital heart abnormality	Yes	No	_____
Heart murmur	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 your 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	At what age _____ Reason _____

Genitourinary:

Urinary Tract Infections	Yes	No	_____
Other abnormalities	Yes	No	_____

Integumentary:

Eczema	Yes	No	_____
Recurrent Rashes	Yes	No	_____
Other skin abnormalities	Yes	No	_____

Endocrine:

Diabetes	Yes	No	_____
Thyroid abnormalities	Yes	No	_____
Other hormonal 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

 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	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? _____

In the past month:

Travel outside of Area	Yes	No	Location: _____
Travel outside of US	Yes	No	Location _____

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:

I have reviewed the above information with the patient.

Physician Name & Signature

Date