NorthShore
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Division of Otolaryngology

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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 you 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):

	Circle One		If Yes, please explain
General:			
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 1st 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 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 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