NorthShore
University HealthSystem

Division of Otolaryngology

Main Phone: 847 570-1360
Main Fax: 847 733-5360

Judy L. Chen, MD
Mark E. Gerber, MD, FACS, FAAP
Joseph Raviv, MD
Ilana Seligman, MD, FACS, FAAP
Michael J. Shinners, MD
Barry Wenig, MD, MPH, FACS

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):

	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