

Name: _____ Age: _____ Referred by: _____

Reason for Visit? _____ Duration of Symptoms: _____

Describe the problem: _____

Medications: (List current medications and dosages)

- 1)
- 2)
- 3)
- 4)

Medication Allergies:

Other Allergies:

Past Medical History: (List with dates)

Illnesses/Medical problems:

Injuries:

Operations:

Does the child have or had in the past:

- Asthma Persistent cough Snoring Mouth breathing Gasping/pausing in breathing at night Nasal discharge
- Nasal congestion Strep infections (How many? _____ per year for _____ years)
- Tonsillitis (How many? _____ per year for _____ years) Bad breath Scarlet fever Hearing loss Ear infections
- Hoarseness Trouble swallowing Seizures Heart problems Diabetes RSV Lyme disease Headaches

Are the child's immunizations up to date? Yes No

Is the child in daycare? Yes No

Is the child exposed to secondhand smoke? Yes No

Has the child seen an allergist? Yes No

Has the child received allergy shots? Yes No

Does the child or any family member have a bleeding disorder? Yes No

- Hemophilia Hemorrhage at surgery Easy bleeding/bruising Slow clotting

Has the child or any family member had problems with anesthesia? Yes No If yes, be specific _____

Were there any complications with the pregnancy or delivery? Yes No If yes, be specific _____

Delivery type Vaginal C-section

Length of pregnancy Term (normal) Premature _____ # weeks

Did the child go home from the hospital within 24 hours? Yes No If no, why? _____

Does any family member have: Asthma Diabetes Tuberculosis High blood pressure Stroke
 Heart disease Allergies Cancer Thyroid disease Thyroid cancer Hearing loss

I have reviewed this information and find it to be correct. Guardian _____ Date _____

Doctor _____ Date _____