

Dubuque ENT, Head and Neck Surgery, PC
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Name: _____
DOB: ___/___/___ age: _____
Todays date: ___/___/___

Child/Minor Patient Medical History

What is the main reason for today's visit?

How long has this been a problem? ___ Hours ___ Days ___ Weeks ___ Months ___ Years
Please list any other complaints you want to discuss today

Who is the child's pediatrician or family doctor? _____

Has your child ever taken antibiotics, over the counter meds or other medications for this problem? Yes No
If so, please list. _____

Have X-rays, CT scans, MRI scans or allergy tests been obtained for this problem? Yes No
If so, when and where were they taken? _____

Past Medical History

Was your child born full term? Yes No
Any problems with the child's growth and development? Yes No
If yes, please explain _____

Please write down any **previous surgeries** and the approximate dates

Does your child have any **medical problems** that require regular visits to the doctor? (Please check):

- | | | |
|---|--|---|
| <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Ear infections | <input type="checkbox"/> Migraine headache |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Eye problems | <input type="checkbox"/> Muscle/bone problems |
| <input type="checkbox"/> Asthma/Reactive Airway disease | <input type="checkbox"/> Gastrointestinal problems | <input type="checkbox"/> Reflux/heartburn |
| <input type="checkbox"/> Bleeding problems/bruising | <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Sinus problems |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Liver/kidney disease | <input type="checkbox"/> Skin disease/rash |
| <input type="checkbox"/> Leukemia/lymphoma | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Thyroid gland problems |

Other: _____

List all medications, including aspirin, other the counter medicines and vitamins, your child takes regularly:

LIST ANY MEDICATIONS OR SUBSTANCES YOUR CHILD IS ALLERGIC TO: _____

Family History Please list any relatives that have or have had any of the following:

Hearing loss ___ How related _____	Cancer ___ How related _____
Diabetes ___ How related _____	Asthma ___ How related _____
Heart trouble ___ How related _____	Allergies ___ How related _____
Bleeding or clotting problems ___ How related _____	

Social History

Who lives at home with the patient? _____
Does anyone at home smoke? Yes No
Are there pets in the home? Yes No
Is the child in school or day care ? Yes No

Review of Systems Please circle any problems the child is currently having.

Body as a Whole

Fatigue
Fevers
Weight loss
Weight gain

Head

Headache
Facial pain
Flat spot

Eyes

Mattering
Redness
Dark circles

Ears

Drainage
Decreased hearing
Fluid
Recurrent infection
Pain
Speech delay
Imbalance/not walking
Dizziness

Nose

Drainage
Stuffiness
Bad smell
Polyps
Foreign object
Bleeding
Frequent colds

Allergies

Sneezing
Pets in home
Spring
Summer
Fall
Winter
Foods

Throat

Drainage
Pain
Tonsillitis
Bad breath
Snoring
Large tonsils
Noisy breathing
Throat clearing
Hoarseness
Cough

Neck

Large glands
Pain
Cyst or lump
Thyroid problems

Lungs

Asthma
Wheezing
Bronchitis

Heart

Murmur
Surgery
Extra beats

Stomach

Diarrhea
Constipation
Cramps
Heartburn

Muscle/Bones

Joint pain
Joint swelling
Weakness

Urinary Tract

Frequency
Burning
Stones

Neurological

Seizures
Numbness
Paralysis
Tremor

Psych

Attention deficit
Depression
Anxiety

Skin

Eczema
Itching
Hives
Rash
Moles