

Child History Sheet – Midwest Ear, Nose & Throat, P.A.

Name _____ Today's Date _____

Nickname _____ Sex: M ___ F ___ Birth Date _____ Age _____

Reason for seeing the doctor today? _____

Does your child have any **ALLERGIES** to medications? _____

Child's current medications and dosage? _____

PAST MEDICAL HISTORY

Surgeries (list dates) _____

Hospitalizations (nonsurgical) _____

Has your child ever had any of the following?

- | | | |
|--|---|--|
| <input type="checkbox"/> Ear Problems | <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Allergies/allergy shots |
| <input type="checkbox"/> Speech Difficulty | <input type="checkbox"/> Visual Changes | <input type="checkbox"/> Frequent Infections |
| <input type="checkbox"/> Heart Trouble | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Lung Infections | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Reaction to Anesthesia |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Kidney Disorder | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Skin Disorder | <input type="checkbox"/> Seizure | <input type="checkbox"/> Mental Disorder |
| <input type="checkbox"/> Diabetes | Other _____ | |

FAMILY HISTORY

Have any relatives ever had any of the following? If so, whom?

- | | |
|------------------------------|-----------------------|
| Allergies _____ | Cancer _____ |
| Asthma _____ | Glaucoma _____ |
| Reaction to Anesthesia _____ | Diabetes _____ |
| Bleeding Disorder _____ | Thyroid Disease _____ |
| Hearing Loss _____ | Mental Illness _____ |
| Heart Disease _____ | Osteoporosis _____ |
| High Blood Pressure _____ | Migraine _____ |
| Stroke _____ | Tuberculosis _____ |
| Kidney Disease _____ | Arthritis _____ |

SOCIAL HISTORY

Child's birth weight _____ Were there any birth complications? _____

Up to date on immunizations? ()Yes ()No ()Don't know

Cigarette smoke exposure? ()Yes ()No

Is your child in daycare? ()Yes ()No Number of children in the daycare? _____

Is your child in school? ()Yes ()No What grade? _____

Please list brothers/sisters, and their ages _____

For office use only

Reviewed/Updated ___/___/___; ___/___/___; ___/___/___; ___/___/___; ___/___/___; ___/___/___

___/___/___; ___/___/___; ___/___/___; ___/___/___; ___/___/___; ___/___/___