Currens Lane Melvin
Moore Rheney Roberts
Seal Audio

Asheville Ear Nose & Throat
PEDIATRIC (0-12 years)
MEDICAL HISTORY

ID #:_____
(For Office Use Only)

Date: _____ Home Phone: **( ) -**

Patient Name: _____ Age: _____ Birthdate: / /

Referring Physician: *(First and Last Name)* _____

Family Physician: *(First and Last Name)* _____

Brief reason for today's visit: _____

Questions Regarding Patient (Circle One)

Exposed to Smoke? YES NO

Premature Birth? YES NO How Early? _____

Siblings? YES NO

-How Many? _____

In Daycare? YES NO

Lives With Whom? _____

List Past Surgeries: *(name and year of surgery)*

_____
_____
_____
_____
_____
_____
_____
_____

Past Medical History: *Please complete the questionnaire to the best of your memory. If there is a question about an item, please ask for assistance.* ***Circle yes or no for each item.*** *Thank you.*

Cardiovascular
YES NO Heart problems

Endocrine
YES NO Diabetes
YES NO Thyroid disease

Pulmonary
YES NO Asthma
YES NO Sleep apnea
YES NO Cystic Fibrosis

Skin
YES NO Eczema
YES NO Birthmarks

Intestinal
YES NO Acid reflux
YES NO Jaundice

Child Immunology
YES NO Current Immunizations
YES NO Immune Problems

Urinary
YES NO UTI

Orthopedic
YES NO Joint Pain

Neurologic
YES NO Headaches
YES NO Seizures

Hematology / Lymphatic
YES NO Bleeding disorder

Cancer
YES NO Thyroid cancer
YES NO Head & neck cancer
YES NO Other: _____

Other Medical Problems: _____

Family History: *Please specify which member of your family (only needed for mother, father, sister, brother) have had the following medical problems.*

YES NO Cancer (what kind) _____
YES NO High blood pressure _____
YES NO Heart attack _____
YES NO Bleeding problems

YES NO Reactions to Anesthesia _____
YES NO Diabetes _____
YES NO Hearing loss _____
YES NO Other diseases

Form completed by: _____ Signature: _____

→ → → → **OVER** → → → →

List Medications: *(include those you buy without a prescription, include vitamins & natural products):*

Medications Patient is Allergic to: *(list reactions)*

PHARMACY INFORMATION *Please provide at least the name and approximate location for prescription purposes.*

Name: _____ Phone Number: ( ) -

Address: _____ City: _____ State: ____

Current Symptoms: *Please complete the questionnaire to the best of your memory. If there is a question about an item, please ask for assistance.* ***Circle yes or no for each item.*** *Thank you.*

Ear

YES	NO	Hearing loss
YES	NO	Ringing in the ears
YES	NO	Ear pain

Nose

YES	NO	Nasal obstruction

Throat

YES	NO	Difficulty swallowing
YES	NO	Hoarseness
YES	NO	Sore throat

Cardiovascular

YES	NO	Irregular heartbeat
YES	NO	Angina or chest pain
YES	NO	Shortness of breath with exertion

Eyes

YES	NO	Double vision
YES	NO	Change in vision

Allergy/Immunology

YES	NO	Seasonal allergies
YES	NO	Allergy skin test positive
YES	NO	Itchy eyes
YES	NO	Itchy nose

Endocrine

YES	NO	Excessive thirst
YES	NO	Excessive urination
YES	NO	Hormone problems
YES	NO	Heat intolerance
YES	NO	Cold intolerance

Pulmonary

YES	NO	Snoring
YES	NO	Chronic cough
YES	NO	Coughing up blood
YES	NO	Shortness of breath
YES	NO	Wheezing

Skin

YES	NO	Rashes
YES	NO	Scar easily

Intestinal

YES	NO	Indigestion
YES	NO	Vomit blood
YES	NO	Change in bowel habits
YES	NO	Heartburn

Constitutional

YES	NO	Night sweats
YES	NO	Weight loss
YES	NO	Fatigue
YES	NO	Fever

Urinary

YES	NO	Difficulty urinating
YES	NO	Blood in urine
YES	NO	Recurrent UTI

Orthopedic

YES	NO	Spine problems
YES	NO	Bone problems
YES	NO	Numbness in hands or feet

Neurologic

YES	NO	Headaches
YES	NO	Weakness or numbness
YES	NO	Depression
YES	NO	Dizziness

Hematology / Lymphatic

YES	NO	Bleed/bruise easily
YES	NO	Anemia