Currens Lane Melvin
Moore Rheney
Roberts Seal Audio

Asheville Head Neck & Ear Surgeons, PA

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