

CHILDREN'S EAR, NOSE & THROAT ASSOCIATES NEW PATIENT QUESTIONNAIRE

PATIENT NAME _____ DOB _____ DATE _____

REFERRING PHYSICIAN _____ PHONE: _____

OTHER PHYSICIANS/SPECIALISTS WHO CARE FOR YOUR CHILD: _____

DESCRIBE WHY YOUR CHILD IS HERE TO SEE THE OTOLARYNGOLOGIST: _____

ANY PROBLEMS DURING PREGNANCY OR BIRTH OF YOUR CHILD ___ YES ___ NO

IF YES, PLEASE EXPLAIN: _____

BIRTH WEIGHT _____ HOSPITAL BORN AT: _____

DID YOUR BABY STAY IN THE HOSPITAL MORE THAN 2 DAYS AFTER BEING DELIVERED? ___ YES ___ NO

IF YES, PLEASE EXPLAIN: _____

HAS YOUR CHILD HAD ANY OF THE FOLLOWING:

EAR INFECTIONS? ___ YES ___ NO

SINUS INFECTIONS? ___ YES ___ NO

THROAT INFECTIONS? ___ YES ___ NO

SLEEP APNEA OR DISTURBED BREATHING WHEN ASLEEP? ___ YES ___ NO

HEART OR CARDIAC PROBLEMS? ___ YES ___ NO

BREATHING OR LUNG PROBLEMS? ___ YES ___ NO

STOMACH OR DIGESTIVE PROBLEMS? ___ YES ___ NO

KIDNEY OR BLADDER PROBLEMS? ___ YES ___ NO

NEUROLOGICAL/SEIZURE PROBLEMS? ___ YES ___ NO

THYROID/BLOOD SUGAR PROBLEMS? ___ YES ___ NO

DELAYS IN DEVELOPMENT? ___ YES ___ NO

DOES YOUR CHILD HAVE ANY DIFFICULTY HEARING? ___ YES ___ NO

ANY CONCERNS ABOUT YOUR CHILD'S SPEECH DEVELOPMENT? ___ YES ___ NO

HAS YOUR CHILD EVER BEEN HOSPITALIZED? ___ YES ___ NO

IF YES, LIST REASON AND DATES: _____

HAS YOUR CHILD EVER HAD SURGERY? ___ YES ___ NO

CIRCUMCISION? ___ YES ___ NO

PLEASE LIST ALL SURGERY, DATES AND WHAT SURGEON:

NAME OF MEDICATION/DOSAGE AND HOW OFTEN/PRESCRIBING MD:

_____/_____/_____
_____/_____/_____
_____/_____/_____
_____/_____/_____

DOES YOUR CHILD HAVE ANY DRUG ALLERGIES? ___ YES ___ NO

IF YES PLEASE LIST DRUG ALLERGIES _____

DOES YOUR CHILD HAVE ENVIRONMENTAL ALLERGIES? ___ YES ___ NO

IS YOUR CHILD IN DAYCARE? ___ YES ___ NO

BOTTLE USE? ___ YES ___ NO

PACIFIER USE? ___ YES ___ NO

IF SCHOOL AGE, WHAT SCHOOL DOES YOUR CHILD ATTEND? _____

WHAT GRADE? _____

FAMILY HISTORY OF HEARING LOSS? ___ YES ___ NO

IF YES, RELATIONSHIP TO CHILD: _____ AGE OF HEARING LOSS _____

OTHER INFORMATION YOU WOULD LIKE TO TELL THE ENT SPECIALIST:

I HAVE HAD THE OPPORTUNITY TO REVIEW THE NOTICE OF PRIVACY PRACTICES AND HAVE NO OTHER QUESTIONS:

SIGNATURE _____ DATE: _____

WITNESS: _____ DATE: _____