Otolaryngology – Head and Neck Surgery

Childhood Health Survey (0 –15 years)

Patients name: ______________________________DOB: _______________Date:________________

Past and Current Medical Problems – *Please check either yes or no.*								
Y	**N**		**Y**	**N**		**Y**	**N**	
		Asthma			High Blood Pressure			Depression
		Migraine Headaches			Irregular Heart Beat			Hepatitis
		TB			Rheumatic Fever			Thyroid Disorders
		Valley Fever			Heart Valve Problems			Diabetes Mellitus

Family Medical History – *Please indicate yes or no if any of your family members, such as grandparents, aunts, uncles brothers, sisters or cousins, have any of the following diseases.*			
Disease	**Y**	**N**	**If Yes, State Relationship**
Allergies			
Bleeding Disorders			
Anesthetic Reactions			
Thyroid Cancer			
Hearing Loss			

Social History

Primary Care-taker during the day: ____

Does your child attend day-care? Yes or No

What grade is your child in: ___________________

What school does he/she attend: ____

	Age	Occupation	Do You Smoke?	Lives at Home?
Mothers Name:				
Fathers Name:				
Stepfathers Name:				
Stepmothers Name:				

More on the reverse side.

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Reviewed by _______________Date: ________________

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Patients name: ______________________________DOB: _______________Date:________________

Current Medications – *If you have a list please ask our receptionist to make a copy for you. If none, please indicate as "none".*		

Allergies – *Please list allergies to medications, or foods. If none, please indicate as "none".*	
Substance	**Type of Reaction**

Previous Surgeries – *If none, please indicate as "none".*	
Date	**Type of Surgery**

Previous Non-surgical Hospitalizations – *If none, please indicate as "none".*	
Date	**Type of Illness**

Review of Systems – *Please check each box for symptoms that apply.* ***Check N/A Only if None Apply!***
○ Fatigue ○ Weight loss ○ Fever ○ Night sweats ○ Weight gain ○ N/A
○ Rashes ○ Itching ○ Hives ○ N/A
○ Seasonal allergies ○ Sneezing ○ N/A
○ Vision changes ○ Double vision ○ Headaches ○ Blackout spells ○ N/A
○ Shortness of breath ○ Snoring ○ Daytime sleepiness ○ Wheezing ○ Cough ○ N/A
○ Chest pain ○ Fainting episodes ○ N/A
○ Swallowing difficulty ○ Abdominal pain ○ N/A
○ Excessive bleeding or bruising ○ Swollen glands ○ N/A
○ Swelling in joints ○ Stiffness ○ N/A

Thank you for your cooperation!

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