# 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.**

**OFFICE USE ONLY**

Reviewed by ________________Date: _________________

Higuera Health Center
1555 Higuera Street
San Luis Obispo, CA 93401
Phone 805.541.2368 • Fax 805.556.3009

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!**

**OFFICE USE ONLY**
Reviewed by ________________Date: _________________

Higuera Health Center
1555 Higuera Street
San Luis Obispo, CA 93401
Phone 805.541.2368 • Fax 805.556.3009