

Midwest Ear, Nose & Throat Specialists: Young Adult/Child

Last name: _____ First name: _____ Age: _____

Grade level: _____ Acct #: _____

Referring Doctor: _____ Other doctor: _____

Medical History

Check (✓) conditions your child currently has or has had in their lifetime.

- Anemia
- Anorexia/Bulimia
- Asthma
- Attention Deficit Disorder
- Bleeding Disorder
- Bronchitis/Pneumonia
- Cancer: type _____
- Cleft Lip/Palate
- Congenital Syndrome
- Cranio-facial Syndrome
- Diabetes
- Epilepsy/Seizures
- Food Allergies
- Heart Disease: type _____
- Hepatitis
- HIV/AIDS
- Inhalant Allergies
- Kidney Disease: type _____
- Migraine
- Psychiatric Care: _____
- Sleep Apnea
- Suicide Attempt
- Thyroid Problems
- Tuberculosis
- Other: _____
- None

Birth History

Were there any complications of your child's birth? No Yes Please List: _____

Surgical History

List all surgeries your child has had in their lifetime

- Ears Ear Tubes Mastoid: _____ Other _____ None _____
- Nose Sinuses: _____ Other: _____ None _____
- Throat Tonsil/Adenoid Other: _____ None _____
- Heart _____ None _____
- Abdomen Appendix Other _____ None _____

Other Major Surgery: _____

Has your child ever had any problems related to surgery? No Yes _____

Has your family ever had any problems related to surgery? No Yes _____

Hospitalizations

List all hospital admissions and the reason None

Family History

Check (✓) if your blood relatives have had any of the following

- Anesthesia or Surgery problems
- Arthritis
- Asthma
- Bleeding disorder
- Cancer
- Diabetes
- Early hearing loss
- Hay Fever
- Heart disease/Strokes
- High blood pressure
- Kidney disease
- Other _____

Child lives with: mother father other _____

Mother alive deceased Cause of death _____

Father alive deceased Cause of death _____

Healthy Habits

Are your child's immunizations up to date?	yes	no	don't know
Was your child breast-fed?	yes	no	don't know
Does anyone smoke at home?	yes	no	sometimes
Was your child ever exposed to alcohol or illegal drugs?	yes	no	don't know

Symptoms

Check (✓) symptoms your child currently has or has had in the past year

GENERAL

- Fever/Chills/Sweats
- Fainting
- Loss of Sleep
- Loss of Weight

EYES

- Blurred Vision
- Crossed Eyes
- Double Vision

CARDIOVASCULAR

- Chest Pain
- Irregular heart beat
- Murmur

EYE, ENT

- Difficulty Swallowing
- Ear pain/discharge
- Loss of Hearing
- Nosebleeds
- Ringing in ears
- Sinus problems

GASTROINTESTINAL

- Poor appetite
- Bowel Changes
- Nausea
- Stomach pain
- Vomiting

RESPIRATORY

- Persistent cough
- Hoarseness
- Shortness of Breath

MUSCLE/JOINT/BONE

Pain, weakness, numbness in:

- Arms/Shoulders
- Back/Neck
- Hips/Legs
- Feet/Hands

GENITO-URINARY

- Blood in urine
- Lack of bladder control
- Painful urination

NEUROLOGIC

- Chronic Pain
- Dizziness
- Headache
- Numbness

PSYCHIATRIC

- Anxiety
- Depression
- Hyperactivity

ENDOCRINE

- Excessive hunger/thirst
- Thyroid problems

HEMATO/LYMPH

- Enlarged glands
 - Excessive bleeding
- ### ALLERGY/IMMUNO
- Decreased immunity

- Hayfever

- Itching
- Sneezing

SKIN

- Bruise easily
- Hives
- Rash