St. Joseph's
Ear, Nose, Throat & Allergy Clinic

CHILD

Appointment Date _____ Date of Birth _____

Last Name _____ First Name _____

Pharmacy _____

Family Physician _____ Referring Physician _____

What is the reason for your visit today?

_____

How long has this problem been going on?

_____

Status:
- o Acute
- o Chronic
- o Improving
- o Worse
- o No Change
- o Asymptomatic

Frequency:
- o Random
- o Constant
- o Daily
- o Weekly
- o Monthly

Severity:
- o Incapacitating
- o Mild
- o Mild-Moderate
- o Moderate
- o Moderate-Severe
- o Severe

Current medications including dosage: (Do you take Aspirin (Anti-Inflammatory), Coumadin (Anti-Coagulation), or Vitamin E? -please note below)

Do you have allergies to medications including reaction? Latex?

Current Health

Do you currently have any of the following medical problems?

- o Chills
- o Fatigue
- o Fever
- o Weight Loss
- o Weight Gain
- o Ear Drainage
- o Ear Pain
- o Eye Discharge
- o Eye Pain
- o Hearing Loss
- o Nasal Drainage
- o Sinus Pressure
- o Sore Throat
- o Visual Changes
- o Hoarseness
- o Food Sticking
- o Visual Loss
- o Cough
- o Shortness of Breath
- o Hemoptysis (Coughing Blood)
- o Snoring
- o Wheezing
- o Chest Pain
- o Palpitations
- o Heartburn/Reflux
- o Nausea
- o Vomiting
- o Hematuria (Blood in Urine)
- o Urinary Retention
- o Heat Intolerance
- o cold Intolerance
- o Dizziness
- o Gait Disturbance
- o Headache
- o Tremors
- o Anxiety
- o Depression
- o Insomnia
- o Hives
- o Mole Changes
- o Rash
- o Skin Lesion
- o Joint Swelling
- o Muscle Weakness
- o Neck Pain
- o Easy Bleeding
- o Easy Bruising
- o Enlarged Lymph Nodes
- o Contact Allergy
- o Environmental Allergies
- o Food Allergies

o Epistaxis (Nose Bleed)	o Memory Loss	o Seasonal Allergies
o Facial Pain	o Seizures	o Other_____

Surgical History

☐ Never had surgery

☐ Any complications? Anesthesia complications?

Hospitalization History

☐ Never been hospitalized

	Procedure(s)/Hospitalizations	Year		Procedure(s)/Hospitalization(s)	Year
1			1		
2			2		
3			3		
4			4		
5			5		
6			6		

<u>Past</u> Medical History and Family History *Please indicate only close (1st degree) relationships (i.e. mother, father, brother, sister) only. Are your parents alive or deceased? A__ D__ Mother A__ D__ Father

Self	Relative	Condition	Self	Relative	Condition	Self	Relative	Condition
o		Asthma	o		Heart Disease	o		Lupus
o		Anemia	o		Hypertension	o		Thyroid
o		Arthritis			Migraines	o		Other: _____
o		Bleeding Disorder	o		Kidney Disorder	o		Hepatitis _____
o		Cancer-Type: _____	o		Seizure	o		MRSA Site: _____
o		Diabetes	o		Stroke			Date: _____
o		GERD/Reflux	o		Renal Disease			
o		Allergies	o		Mental Disease			

Smoking Status (for teens only)

☐ Current every day ☐ Current some days ☐ Former ☐ Never ☐ Unknown

Type: ☐ Cigarettes ☐Chew ☐ Other Units/day

Ever tried to quit? ☐ Yes ☐ No Passive smoke exposure? ☐Yes ☐ No

Longest tobacco free Age Started Age quit

Alcohol Status (for teens only)

Drinks alcohol ☐ Yes ☐ No ☐ Former

Do you wear glasses? ☐ Yes ☐ No Do you wear hearing aid(s) ? ☐ Yes ☐ No

Social History

Is the child in daycare? ☐ Yes ☐ No Days per week:

Race Ethnicity ☐ Hispanic or Latino

Language ☐ English ☐Other

Illegal Drug Status (for teens only)

Use drugs ☐ Yes ☐ No ☐ Former Type Frequency

Do you have a history of or do you have HIV? ☐ Yes ☐ No