Otolaryngology – Head and Neck Surgery

Childhood Health Survey (0-15 years)

Patients name: ____ 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:** ___________________

Patients name: ____ Date: _______________________

Current Medications including supplements and vitamins *(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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Reviewed by ____________________ Date: __________________