

OUTPATIENT PEDIATRIC OTOLARYNGOLOGY PATIENT MEDICAL HISTORY QUESTIONNAIRE

Patient Name

Medical Record Number

FORM NO. 2613 Rev. (12/11)

Medical History Reviewed by _____

Page 1 of 1 Birthdate

	Children's Hospit	al of Pitts	burgh Department	of Pec	diatric Otolaryng	ology			
PATIENT MEDICAL HISTOR	RY QUESTIONNAIRE: C	hildren's Hos	spital of Pittsburgh Depa	rtment of	Pediatric Otolaryngol	ogy req	uests th	is informa	ition for
the purpose of providing pati information, patient care may	ient care. No persons ou , be impaired. Please asl	tside the CH k for help if y	P are provided this inform ou have difficulties with t	mation withe quest	ithout your consent. I	f you fai	I to prov	ide the re	quested
Child's Name						Date of	Visit	/	/
CHIEF COMPLAINT									
What is your child being see	n for today?								
How long has your child had	this problem?								
What medications have beer	used to treat this proble	m?							
REFERRING DOCTOR	☐ NO CHANGE FROM	I I AST VISIT	-						
Please list any other physicia									
	·	•					,		
PAST MEDICAL HISTORY	□ NO CHANGE FR	-	_						
Does your child have any ser		☐ Yes	□ No						
If yes, please list the name of	feach and the type of rea	action:							
Does your child have any see	ods?	☐ Yes	□ No						
If yes, please list the name of	f each and the type of rea	action:							
Does your child have any allergy to latex?				☐ Yes	□ No				
Does your child have easy b	hilia?	☐ Yes	□ No						
Please list any surgeries or h	ospitalizations your child	has had:							
Surgery/Reason for Hospitalization			Date		Col	nplicatio	ons		
Please list any other major ill	nesses and/or other injur	ies							
	OUANGE EDOM 1 407								
MEDICATIONS ☐ NO Please list your child's currer	CHANGE FROM LAST 'n medication. Include an		ol pill, steroid, over-the-c	ounter m	nedications, ear drops	nose d	rops. vit	amins, di	etarv
supplements, ointments, trac		,	p,						- · · · · · ·
Current Medications			Dose		F	requenc	·		
							,		
	NO CHANGE FROM LAS		•						
Please check any medical pr	oblems that run in your o	hild's family	(grandparents, parents,	and sibli	ngs)				
Diabetes	Cancer	Pr	oblems with Anesthesia		Cleft Lip/Cleft Palate	9		Reflux Dis	sease
Heart Disease	Kidney Disease		Bleeding problems		Immune disorde	r		Birth De	efects
Sinus Disease	Thyroid Disease		Sickle Cell Disease		Hearing los	3		Ear infed	ctions
Migraines	Asthma		Allergies/Hay Fever		Seizure	s		Cystic Fil	orosis
Please Specify (who):					Other:				
SOCIAL HISTORY	NO CHANGE FROM LAS	ST VISIT							
Does/Did your child receive I									
Are all immunizations up to d Is the child exposed to tobac				□ No					
Is the child in daycare?	co smoke in the nome, o				ide?				
Are there any pets at home?		Yes □ No	If Yes, please list						
How many people live in the	household?	Adults	Children						
Completed by		5	elationahin to Dationt		Data				

_____ Date _____ Time ____