UPMC | CHILDREN'S HOSPITAL OF PITTSBURGH

OUTPATIENT PEDIATRIC OTOLARYNGOLOGY
PATIENT MEDICAL HISTORY QUESTIONNAIRE

Form CHP-2613 11/19

Patient Name

Medical Record Number

Birthdate

Children's Hospital of Pittsburgh Department of Pediatric Otolaryngology

PATIENT MEDICAL HISTORY QUESTIONNAIRE: Children's Hospital of Pittsburgh Department of Pediatric Otolaryngology requests this information for the purpose of providing patient care. No persons outside the CHP are provided this information without your consent. If you fail to provide the requested information, patient care may be impaired. Please ask for help if you have difficulties with the questions.

Child's Name: _____ Sex: ☐ M ☐ F
Birthdate: _____/_____/_____ Date of Visit: _____/_____/_____

CHIEF COMPLAINT

What is your child being seen for today?_____
_____
_____
How long has your child had this problem? _____
What medications have been used to treat this problem? _____
_____
_____

PHYSICIAN INFO

Primary Care Physician (First and Last Name): _____
Referring Doctor (First and Last Name) if different from PCP above: _____

PAST MEDICAL HISTORY ☐ **NO CHANGE FROM LAST VISIT**

Does your child have any sensitivity or allergic reactions to any medications? ☐ Yes ☐ No
If yes, please list the name of each and the type of reaction: _____
_____
Does your child have any sensitivity or allergic reactions to any foods? ☐ Yes ☐ No
If yes, please list the name of each and the type of reaction: _____
Does your child have any allergy to latex? ☐ Yes ☐ No
Does your child have easy bruising, prolonged bleeding or hemophilia? ☐ Yes ☐ No
Please list any surgeries or hospitalizations your child has had:

Surgery/Reason for Hospitalization	*Date*	*Complications*

Please list any other major illnesses and/or other injuries _____
_____

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MEDICATIONS ☐ **NO CHANGE FROM LAST VISIT**

Please list your child's current medication. Include any birth control pill, steroid, over-the-counter medications, ear drops, nose drops, vitamins, dietary supplements, ointments, traditional treatments.

Current Medications	*Dose*	*Frequency*

FAMILY HISTORY ☐ **NO CHANGE FROM LAST VISIT**

Please check any medical problems that run in your child's family (grandparents, parents, and siblings)

Diabetes		Cancer		Problems with Anesthesia		Cleft Lip/Cleft Palate		Reflux Disease	
Heart Disease		Kidney Disease		Bleeding problems		Immune disorder		Birth Defects	
Sinus Disease		Thyroid Disease		Sickle Cell Disease		Hearing loss		Ear infections	
Migraines		Asthma		Allergies/Hay Fever		Seizures		Cystic Fibrosis	

Please Specify (who): _____ Other: _____

SOCIAL HISTORY ☐ **NO CHANGE FROM LAST VISIT**

Does/Did your child receive breastmilk? ☐ Yes ☐ No If Yes for how long? _____

Are all immunizations up to date? ☐ Yes ☐ No

Is the child exposed to tobacco smoke in the home, car or other indoors? ☐ Yes ☐ No

Is the child in daycare? ☐ Yes ☐ No If attending school, what grade? _____

Are there any pets at home? ☐ Yes ☐ No If Yes, please list _____

How many people live in the household? _____ Adults _____ Children

Completed by: _____ Relationship to Patient: _____ Date: _____

Medical History Reviewed by: _____ Date: _____ Time: _____

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