### UPMC | CHILDREN'S HOSPITAL OF PITTSBURGH

Form CHP-2613 11/19

Child's Name: \_\_\_

### OUTPATIENT PEDIATRIC OTOLARYNGOLOGY PATIENT MEDICAL HISTORY QUESTIONNAIRE

Patient Name

Medical Record Number

Page 1 of 2 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.

Nhat is valir shild haing soon for taday?			
Vhat is your child being seen for today?			
How long has your child had this problem?			
What medications have been used to treat this prob	olem?		
DUVOICIAN INFO			
<b>PHYSICIAN INFO</b> Primary Care Physician (First and Last Name):			
Referring Doctor (First and Last Name) if different f			
,			
PAST MEDICAL HISTORY □ NO CHA	ANGE FROM LAST VISIT		
Does your child have any sensitivity or allergic reac	_	☐ Yes ☐ No	
If yes, please list the name of each and the type of	reaction:		
Does your child have any sensitivity or allergic reac	ctions to any foods?	☐ Yes ☐ No	
	reaction:		
If yes, please list the name of each and the type of	reaction:	☐ Yes ☐ No	
If yes, please list the name of each and the type of Does your child have any allergy to latex? Does your child have easy bruising, prolonged blee	eding or hemophilia?	☐ Yes ☐ No ☐ Yes ☐ No	
If yes, please list the name of each and the type of Does your child have any allergy to latex?	eding or hemophilia?		
If yes, please list the name of each and the type of Does your child have any allergy to latex? Does your child have easy bruising, prolonged blee	eding or hemophilia?		
f yes, please list the name of each and the type of Does your child have any allergy to latex? Does your child have easy bruising, prolonged blee Please list any surgeries or hospitalizations your ch	eding or hemophilia? nild has had:	□ Yes □ No	
If yes, please list the name of each and the type of Does your child have any allergy to latex? Does your child have easy bruising, prolonged blee Please list any surgeries or hospitalizations your ch	eding or hemophilia? nild has had:	□ Yes □ No	
If yes, please list the name of each and the type of Does your child have any allergy to latex? Does your child have easy bruising, prolonged blee Please list any surgeries or hospitalizations your ch	eding or hemophilia? nild has had:	□ Yes □ No	
If yes, please list the name of each and the type of Does your child have any allergy to latex? Does your child have easy bruising, prolonged blee Please list any surgeries or hospitalizations your ch	eding or hemophilia? nild has had:	□ Yes □ No	



Sex: □ M □ F

# UPMC | CHILDREN'S HOSPITAL OF PITTSBURGH

## OUTPATIENT PEDIATRIC OTOLARYNGOLOGY PATIENT MEDICAL HISTORY QUESTIONNAIRE

Patient Name

Medical Record Number

Form CHP-2613 11/19 Page 1 of 2 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

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 proble			
PHYSICIAN INFO			
Primary Care Physician (First and Last Name): Referring Doctor (First and Last Name) if different fro			
PAST MEDICAL HISTORY  □ NO CHAN  Does your child have any sensitivity or allergic reaction  If yes, please list the name of each and the type of re		ons?	
Does your child have any sensitivity or allergic reactions. If yes, please list the name of each and the type of re	☐ Yes ☐ No		
Does your child have any allergy to latex?  Does your child have easy bruising, prolonged bleedi  Please list any surgeries or hospitalizations your child	☐ Yes ☐ No ☐ Yes ☐ No		
Surgery/Reason for Hospitalization	Date	Complications	
Please list any other major illnesses and/or of	other injuries		



2613

#### UPMC | CHILDREN'S HOSPITAL OF PITTSBURGH

Diabetes

### OUTPATIENT PEDIATRIC OTOLARYNGOLOGY PATIENT MEDICAL HISTORY QUESTIONNAIRE

P	а	ti	е	r
Ν	la	n	n	е

Medical Record Number

Cleft Lip/Cleft Palate

Reflux Disease

Form CHP-2613 11/19 Page 2 of 2 Birthdate

Children's Hos	pital of Pittsburg	gh Department	of Pediatric C	Otolaryngology

# 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

Problems with Anesthesia

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

Cancer

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

Heart Disease	Kidney Disease	Bleeding problems		Immune disorder	Birth Defects	
Sinus Disease	Thyroid Disease	Sickle Cell [	Sickle Cell Disease		Ear infections	
Migraines	Asthma	Allergies/Ha	Allergies/Hay Fever		Cystic Fibrosis	
Please Specify (who): Other:						
SOCIAL HISTORY	□ NO CHAN	GE FROM LAST	VISIT			
Does/Did your child re	☐ Yes ☐ No If Yes for how long?					
		☐ Yes ☐ No				
Is the child exposed to tobacco smoke in the home, car or other indoors? ☐ Yes ☐ No						
Is the child in daycare						
Are there any pets at h			_	se list		
• •	in the household?					
Completed by:		Rel	ationship to I	Patient:	Date:	
Medical History Review	wed by:			Date:	Time:	

#### UPMC | CHILDREN'S HOSPITAL OF PITTSBURGH

## OUTPATIENT PEDIATRIC OTOLARYNGOLOGY PATIENT MEDICAL HISTORY QUESTIONNAIRE

Patient Name

Medical Record Number

#### Page 2 of 2 | Birthdate Form CHP-2613 11/19 Children's Hospital of Pittsburgh Department of Pediatric Otolaryngology **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** Frequency Dose **FAMILY HISTORY** ☐ NO CHANGE FROM LAST VISIT Please check any medical problems that run in your child's family (grandparents, parents, and siblings) Cancer Problems with Anesthesia Cleft Lip/Cleft Palate Reflux Disease Diabetes Kidney Disease Heart Disease Bleeding problems Immune disorder Birth Defects Thyroid Disease Sickle Cell Disease Sinus 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 Medical History Reviewed by: \_\_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_