NORTH COUNTY EAR, NOSE, & THROAT
HEAD AND NECK SURGERY, INC.
Pediatric and Adult
3909 Waring Road, Suite A
Oceanside, California 92056
(760) 726-2440 Fax (760)726-0644

PEDIATRIC/TEEN PATIENT MEDICAL HISTORY FORM

1. Patient Name _____ Today's Date _____

Date of Birth _____ Age _____ Height _____ Weight_____

Referring Provider _____ Primary Care Provider _____

2. Chief complaint: What is the reason for your child's visit?

_____

3. Birth history:

YES NO

☐ ☐ Problems with pregnancy or delivery _____

☐ ☐ Hospitalizations in the intensive care unit _____

☐ ☐ Intubations _____

☐ ☐ Intravenous (IV) antibiotics _____

4. Past medical history: Medical problems for which your child has previously been treated or is currently being treated. If yes, please circle specific conditions and provide details if needed. Please add any others not listed.

YES NO

☐ ☐ Acid reflux _____

☐ ☐ AIDS/HIV _____

☐ ☐ Anesthesia problems _____

☐ ☐ Birth Defects _____

☐ ☐ Bleeding problems (eg nose, surgical, gums, menstrual cycle) _____

☐ ☐ Cancer/what type? _____

☐ ☐ Developmental delay (eg speech)_____

☐ ☐ Depression, bipolar, anxiety, other _____

☐ ☐ Diabetes _____

YES NO

☐ ☐ Environmental Allergies _____

☐ ☐ Head or neck radiation _____

☐ ☐ Hearing problems_____

☐ ☐ Heart murmur _____

☐ ☐ Immune problems_____

☐ ☐ Lung Disease (asthma, pneumonia, tuberculosis, other) _____

☐ ☐ Rheumatic fever_____

☐ ☐ Thyroid disease_____

Other _____

5. Surgical history: Please list **any surgeries** and the **dates** they were performed:

_____

_____

Patient Name _____ Date of Birth _____

6. Social history: Who does the child live with? _____

YES **NO**

☐ ☐ Secondhand smoke exposure _____

☐ ☐ Currently in school or daycare _____

☐ ☐ Afterschool care _____

☐ ☐ Activities (sports, music) _____

☐ ☐ Immunizations up to date _____

For teens:

YES **NO**

☐ ☐ Current tobacco use _____

☐ ☐ Past tobacco use _____

☐ ☐ Other drug use (eg. marijuana, other) _____

☐ ☐ Alcohol use _____

7. Family history: Please list any medical problems that may run in the FAMILY (e.g. bleeding problems, anesthesia problems, chronic illnesses, congenital abnormalities etc.): _____

_____

8. Other questions:

YES **NO**

☐ ☐ Currently pregnant_____

☐ ☐ Breastfeeding _____

☐ ☐ Do we have your approval to obtain an HIV test on your child if indicated?

9. Review of systems: If yes, please **circle** Add additional information if needed.

YES **NO**

☐ ☐ **Constitutional:** Fevers, unintentional weight loss, snoring/sleep apnea _____

☐ ☐ **Eyes:** Decreased vision, double vision _____

☐ ☐ **CV:** Chest pain, racing heart _____

☐ ☐ **Pulm**: Shortness of breath, wheezing _____

☐ ☐ **GI:** Nausea, vomiting, diarrhea, abdominal pain _____

☐ ☐ **GU:** Pain when urinating, blood in urine _____

☐ ☐ **MSK:** Sore or painful joints, sore or painful muscles _____

☐ ☐ **Derm/Heme:** Rashes, eczema, excessive bleeding or easy bruising _____

☐ ☐ **Neuro:** Dizziness, fainting, headaches _____

☐ ☐ **Psych:** Depressed, anxious _____

10. Signature of parent or legal guardian _____ **Date** _____

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PEDIATRIC/TEEN PATIENT MEDICATION FORM Today's Date _____

1. Patient Name: _____ **Date of Birth** ___/____/____

2. Pharmacy information: Please list the name, phone number and address of your preferred **pharmacy**:

Pharmacy name: _____ Phone Number: _____

Street Address: _____ City_____ ZIP Code _____

3. Medications: Please list **all** medications your child is currently taking (including herbal supplements, vitamins, aspirin, nasal sprays, other "over-the-counter" medications, etc.) and **dosage:**

Check here if none ☐

Medication	**Dosage**	**Medication**	**Dosage**

4. Allergies: Please list any allergies and the type of reaction (include medications, latex, xray dye, food, environmental):

Check here if none ☐
