

Ear, Nose, Throat & Plastic Surgery, Inc.

Paul E. Burk, D.O., F.O.C.C.O.O.
Anthony J. D'Angelo, D.O., F.O.C.C.O.O.
Richard L. Barnes, D.O., F.O.C.C.O.O.

Erin Cole, M.S., CCC-A, Clinical Audiologist
Brenda Bear, Practice Administrator

Pediatric History

Please answer each question by filling in the appropriate circle fully.

Patient accompanied by: mother father care provider

Is the patient over the age of 18? Yes No

Is the patient accompanied by guardian? Yes No

Does the patient have any medical problems?

- ADHD
- Anemia
- Asthma
- Other lung problems
- Anxiety/Depression
- Developmental delay
- Diabetes
- Dizziness
- Down's syndrome
- Heart murmur
- Irregular heartbeat
- Migraine headache
- Mitral valve prolapse
- Vision problems
- Sinusitis
- Allergies
- Genitourinary problems
- Seizures
- Thyroid problems
- Blood cancer
- Skin problems
- Other, please list: _____
- None

Please List all Medications that you are currently taking: _____

Please List all Allergies to Medications and the reaction you have to them: _____

Please List all Surgeries: _____

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Please answer each question by filling in the appropriate circle fully.

Did patient's mother receive prenatal care? Yes No

Did patient's mother have or use any of the following during pregnancy?

- Infection High Blood pressure Diabetes
 Alcohol tobacco Drugs

Was baby born within 2 weeks of due date? Yes No

Did patient have any complications during newborn nursery stay?

- No
 breathing problems
 Jaundice requiring treatment
 Infection
 Birth injury
 Birth defect

Does anyone in the family: (brothers, sisters, Father, Mother) have...?

- ear problems hearing loss head and neck cancers
 allergies sinus problems other: _____

Does the Patient...?

- Smoke Yes No
Have Second hand smoke exposure Yes No
Drink Alcohol Yes No
Use Smokeless Tobacco Yes No
Use Recreational drug Yes No
Drink Caffeine: Yes No
Attend Daycare: Yes No
Have Pets: Yes No

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Pediatric History

Please answer each question by filling in the appropriate circle fully.

Has the patient experienced any of the following in the last 6 months?

- | | |
|------------------------|--|
| fever | <input type="radio"/> Yes <input type="radio"/> No |
| chills | <input type="radio"/> Yes <input type="radio"/> No |
| weight change | <input type="radio"/> Yes <input type="radio"/> No |
| loss of appetite | <input type="radio"/> Yes <input type="radio"/> No |
| hearing loss | <input type="radio"/> Yes <input type="radio"/> No |
| sore throat | <input type="radio"/> Yes <input type="radio"/> No |
| epistaxis | <input type="radio"/> Yes <input type="radio"/> No |
| change in voice | <input type="radio"/> Yes <input type="radio"/> No |
| ringing in ears | <input type="radio"/> Yes <input type="radio"/> No |
| dizziness | <input type="radio"/> Yes <input type="radio"/> No |
| used Q-tips | <input type="radio"/> Yes <input type="radio"/> No |
| allergies | <input type="radio"/> Yes <input type="radio"/> No |
| ear pain | <input type="radio"/> Yes <input type="radio"/> No |
| ear drainage | <input type="radio"/> Yes <input type="radio"/> No |
| ear fullness | <input type="radio"/> Yes <input type="radio"/> No |
| high blood pressure | <input type="radio"/> Yes <input type="radio"/> No |
| irregular heart rhythm | <input type="radio"/> Yes <input type="radio"/> No |
| murmur | <input type="radio"/> Yes <input type="radio"/> No |
| nausea | <input type="radio"/> Yes <input type="radio"/> No |
| vomiting | <input type="radio"/> Yes <input type="radio"/> No |
| diarrhea | <input type="radio"/> Yes <input type="radio"/> No |
| heartburn | <input type="radio"/> Yes <input type="radio"/> No |
| rash | <input type="radio"/> Yes <input type="radio"/> No |
| hives | <input type="radio"/> Yes <input type="radio"/> No |
| itching | <input type="radio"/> Yes <input type="radio"/> No |
| diabetes | <input type="radio"/> Yes <input type="radio"/> No |
| thyroid disease | <input type="radio"/> Yes <input type="radio"/> No |

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Please answer each question by filling in the appropriate circle fully.

Has the patient experienced any of the following in the last 6 months?

- | | |
|----------------------|--|
| headache | <input type="radio"/> Yes <input type="radio"/> No |
| tingling or numbness | <input type="radio"/> Yes <input type="radio"/> No |
| memory loss | <input type="radio"/> Yes <input type="radio"/> No |
| blurring of vision | <input type="radio"/> Yes <input type="radio"/> No |
| | |
| asthma | <input type="radio"/> Yes <input type="radio"/> No |
| cough | <input type="radio"/> Yes <input type="radio"/> No |
| wheezing | <input type="radio"/> Yes <input type="radio"/> No |
| | |
| sinus congestion | <input type="radio"/> Yes <input type="radio"/> No |
| stuffy nose | <input type="radio"/> Yes <input type="radio"/> No |
| runny nose | <input type="radio"/> Yes <input type="radio"/> No |
| scratchy throat | <input type="radio"/> Yes <input type="radio"/> No |
| itchy eyes | <input type="radio"/> Yes <input type="radio"/> No |
| | |
| easy bruising | <input type="radio"/> Yes <input type="radio"/> No |
| anemia | <input type="radio"/> Yes <input type="radio"/> No |
| | |
| visual changes | <input type="radio"/> Yes <input type="radio"/> No |
| | |
| arthritis | <input type="radio"/> Yes <input type="radio"/> No |
| muscle aches | <input type="radio"/> Yes <input type="radio"/> No |
| | |
| rheumatoid arthritis | <input type="radio"/> Yes <input type="radio"/> No |