ONSLOW
EAR NOSE & THROAT

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# PEDIATRIC HISTORY FORM

(Please Print)

| Name | Dob | Age | Sex ❑ M ❑ F |
|---|---|---|---|
| | | | |

**BIRTH HISTORY**

Were there any complications during the pregnancy or at birth ❑ No Yes-please explain:

❑ jaundice ❑ respiratory distress ❑ feeding problems

| If premature, born at how many weeks? | Delivery: ❑ vaginal ❑ c-section ❑ breech | Length | Weight |
|---|---|---|---|
| | | | |

**ALLERGIES** to any medications, X-Ray dyes or other substances? ❑ No ❑ Yes (if yes, please the list the type of reaction)

**MEDICATIONS-**names, dosages

| | | | |
|---|---|---|---|
| | | | |
| | | | |

**IMMUNIZATIONS**

Are your child's immunizations up to date? ☐ Yes ☐ No ☐ Unsure

**PAST MEDICAL HISTORY**

Any delays in development? ☐ No ☐ Yes-explain: ☐ motor ☐ speech ☐ hearing

| | | | | |
|---|---|---|---|---|
| ☐ADD/ADHD | ☐Anemia | ☐Acid Reflux | ☐Appendix removal | ☐Asthma |
| ☐Blood Transfusion | ☐Cancer | ☐Chicken pox | ☐Chronic ear infections | ☐Diabetes |
| ☐Eczema | ☐Epilepsy | ☐Eye or vision problems | ☐Heart Murmur | ☐Hernia/Hernia repair |
| ☐Kidney/bladder problems | ☐Liver disease/jaundice | ☐Mono | ☐Rheumatic fever | ☐Tuberculosis |

Other:

**FAMILY HISTORY** Adopted? ☐ Yes- you may skip this section

| Illness | Father | Mother | Sibling (s) |
|---|---|---|---|
| Bleeding/Clotting Disorder | ☐ | ☐ | ☐ |
| Cancer (list the type) | | | |
| Depression/Anxiety | ☐ | ☐ | ☐ |
| Diabetes | ☐ | ☐ | ☐ |
| Heart Attack | ☐ | ☐ | ☐ |
| High Blood Pressure | ☐ | ☐ | ☐ |
| High Cholesterol | ☐ | ☐ | ☐ |

**SOCIAL AND ENVIRONMENTAL HISTORY**

| Who does the child live with? | Is the home tobacco free? |
|---|---|
| | |

**I attest that the above information is accurate to the best of my knowledge.**

Parent/Guardian Name _____ Parent/Guardian Signature _____ Date _____