BECKER
EAR, NOSE & THROAT CENTER

Pediatric Patient Intake Form

Date:_____

Patient Name: _____ Date of Birth: _____ Sex: ☐ M ☐ F

Referring/Family Doctor: _____ Tel #: _____

Please complete this form so we can facilitate your care or provide resource information regarding available services. If you are offended by the personal nature of the question content, you do not have to answer.

CHIEF COMPLAINTS

Please list all reason(s) for your child's visit:

_____

HISTORY OF PRESENT ILLNESS

How long have these problems been present and when did they start? _____

Rate severity of problem on a scale of 1 to 10: _____

What types of activities aggravate this/these problems? _____

What makes these symptoms better? _____

What types of treatments/medications has your child received for this/these problems? Have they helped?

_____

MEDICATIONS

Is your child taking any medication, drugs or pills? ☐ Yes ☐ No

If yes, please list names and dosage. Please include all prescription and NON-prescription medications (i.e. Motrin, vitamins, herbal supplements, Tylenol, ect.): _____

_____

ALLERGIES

Does your child have any allergic or adverse reactions to any medication or substance? ☐ Yes ☐ No

If yes please list:_____

HPL ASSOCIATED SIGNS & SYMPTOMS

Does your child have environmental allergies (i.e. "hay fever") ☐ Yes ☐ No

If yes, please check which allergy symptoms your child has;

- ☐ Sneezing
- ☐ Runny Nose
- ☐ Itchy Throat
- ☐ Itchy Nose
- ☐ Itchy/Runny/Watery Eyes
- ☐ Itchy Ears

Patient Name: _____

EAR, NOSE AND THROAT HISTORY

	Yes	No		Yes	No
Hearing problems/Ear Fullness/Ear Ringing	☐	☐	Mouth breathing	☐	☐
Ear Infections	☐	☐	Snoring/Sleep problems	☐	☐
Speech delay	☐	☐	Frequent sore throats	☐	☐
Dizziness	☐	☐	Number of times with strep throat		
Cough	☐	☐	this year _____		
Nasal blockage, congestion, or stuffiness	☐	☐	Swallowing problems	☐	☐
Postnasal drip or thick/discolored nasal drainage	☐	☐	Hoarseness	☐	☐
Nasal bleeding	☐	☐	Tongue tie	☐	☐
Sinus pressure, tenderness, or infections	☐	☐	Swollen lymph nodes	☐	☐
Noisy breathing	☐	☐			

PAST MEDICAL HISTORY

Please check if your child suffers from, or has been treated for any of the following medical conditions.

	Yes	No		Yes	No
Abnormal development	☐	☐	Heart disease/problems	☐	☐
Allergies	☐	☐	HIV/AIDS	☐	☐
Arthritis	☐	☐	Immune/autoimmune disorder	☐	☐
Asthma	☐	☐	Lung disease	☐	☐
Attention deficit disorder	☐	☐	Muscle/bone disorder	☐	☐
Bleeding tendencies	☐	☐	Neurological disorder	☐	☐
Cancer	☐	☐	Seizures	☐	☐
Depression	☐	☐	Skin rash	☐	☐
Diabetes	☐	☐	Thyroid disorder	☐	☐
Down syndrome	☐	☐	Urinary/kidney disorder	☐	☐
Eye Disease	☐	☐	Migraine headaches	☐	☐
GI disorder/Reflux	☐	☐	Other: _____		

BIRTH HISTORY

Pregnancy complications (list any):_____

Birth weight: _____lbs. _____oz. How many weeks gestation: _____ NICU stay? ☐ Yes ☐ No

Newborn hearing screen results were: ☐ Pass ☐ Fail ☐ Unknown

PAST SURGICAL HISTORY AND HOSPITALIZATIONS

Please list year and reason for any past surgeries or hospitalizations your child has had:

_____

_____

Has your child ever been intubated? ☐ Yes ☐ No

IMMUNIZATIONS

Up to date? ☐ Yes ☐ No

Delayed? ☐ Yes ☐ No

Patient Name: _____

SOCIAL HISTORY

Check all that apply

Who has legal custody of the child? ☐ Both parents ☐ Mother ☐ Father ☐ Other:_____

Child lives with: ☐ Both parents ☐ Mother ☐ Father ☐ Other family ☐ Foster family

Parents are: ☐ Married ☐ Not married ☐ Partnered ☐ Separated ☐ Divorced

Does your child attend: ☐ Daycare ☐ Preschool ☐ Grade in school: _____

Number of siblings: _____ Pets in home? ☐ Dog ☐ Cat ☐ Other:_____

Smokers in house, even if they do not smoke inside? ☐ Yes ☐ No

FAMILY HISTORY

Please check if any of the following diseases run in your child's family, and indicate which relative(s)

	Father	Mother	Brother	Sister
Hypertension	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐
Cancer	☐	☐	☐	☐
Psychiatric illness	☐	☐	☐	☐
Stroke	☐	☐	☐	☐
Asthma	☐	☐	☐	☐
Heart problem	☐	☐	☐	☐
Bleeding tendencies	☐	☐	☐	☐
Other:				
_____	☐	☐	☐	☐
_____	☐	☐	☐	☐

PREVIOUS TESTS PERFORMED

Please indicate type of test, date, and where.

Allergy test ☐ Yes ☐ No Type, date, location: _____

Sweat test ☐ Yes ☐ No Type, date, location: _____

Hearing test ☐ Yes ☐ No Type, date, location: _____

X-ray, CT, MRI ☐ Yes ☐ No Type, date, location: _____

Genetic test ☐ Yes ☐ No Type, date, location: _____

Immune test ☐ Yes ☐ No Type, date, location: _____

Patient Name: _____

REVIEW OF SYSTEMS

Please **CHECK** if your child has had any of the following:

Constitutional
- ☐ Weight gain/loss
- ☐ Fatigue
- ☐ Fever/chills/night sweats

Eyes
- ☐ Blurred vision
- ☐ Visual changes
- ☐ Double vision
- ☐ Corrective lenses

Ears/nose/mouth/throat
- ☐ Ear pain
- ☐ Difficulty in hearing
- ☐ Ringing in the ears
- ☐ Sinus pain
- ☐ Mouth sore/ulcer
- ☐ Gum bleeding
- ☐ Pain on swallowing
- ☐ Hoarseness

Breast
- ☐ Pain
- ☐ Lump/masses
- ☐ Nipple discharge

Respiratory
- ☐ Difficulty breathing
- ☐ Wheezing
- ☐ Coughing up blood

Cardiovascular
- ☐ Chest pain/tightness
- ☐ Palpitation
- ☐ Shortness of breath
- ☐ Heart attack
- ☐ Leg pain when walking
- ☐ Swelling of hands/feet/legs

Gastrointestinal
- ☐ Loss of appetite
- ☐ Constipation
- ☐ Bloating/belching
- ☐ Abdominal pain
- ☐ Nausea and vomiting
- ☐ Diarrhea
- ☐ Change in bowel habits
- ☐ Bloody stool
- ☐ Hemorrhoids

Genitourinary
- ☐ Frequent urination
- ☐ Pain on urination
- ☐ Hesitancy
- ☐ Incontinence
- ☐ Blood in urine
- ☐ Impotence
- ☐ Prostate problem
- ☐ Menstrual problem

Musculoskeletal
- ☐ Joint pain or swelling
- ☐ Muscle pain/bone pain

Integumentary/Skin
- ☐ Skin color/texture change
- ☐ Itching
- ☐ Rashes
- ☐ Ulcers

Neurologic
- ☐ Frequent headaches
- ☐ Numbness
- ☐ Tremors
- ☐ Twitching

Psychiatric
- ☐ Anxiety
- ☐ Feeling depressed

Endocrine
- ☐ Thyroid problems
- ☐ Frequent thirst
- ☐ Excessive sweating
- ☐ Heat/cold intolerance

Hematologic/Lymphatic
- ☐ Easy bruising/bleeding
- ☐ Bleeding tendencies
- ☐ Swollen lymph nodes

I understand the above information is necessary to provide me with surgical/medical care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any change to health or medications.

Form completed by (print): _____

Relationship to patient: ☐ Mother ☐ Father ☐ Other:_____

Patient/Guardian Signature: _____ **Date:** _____

PHYSICIAN USE ONLY:

I have reviewed all information in the health survey and discussed it with the patient/guardian.

Attending Physician Signature: _____ Date: _____

☐ Review of Systems negative except as noted above. Reviewed and discussed with patient's guardian.
Physician Initial/Date _____

☐ For Physical Examination and Endoscopy Procedures, as well as Letters to Referring Physician(s), Lab Results, Results, Radiographic Results, and other related office notes, please also see Electronic Medical Record.
Physician Initial/Date _____