

# M MORELAND

Ear, Nose & Throat Group

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**NEW PATIENT CHILD FORM** - Please answer all of the following questions to the best of your ability.

Patient's Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

**CHIEF COMPLAINT:**

What is the reason for this appointment? \_\_\_\_\_

**HISTORY OF PRESENT ILLNESS:**

Where does it hurt or bother the patient? \_\_\_\_\_

When did the problem start? \_\_\_\_\_

Does anything make it better or worse? \_\_\_\_\_

Any other associated symptoms? \_\_\_\_\_

**PAST MEDICAL HISTORY:**

List any medical conditions the patient has or is being treated for (asthma, etc.) \_\_\_\_\_

\_\_\_\_\_

List any prior surgeries or hospitalizations: \_\_\_\_\_

Was pregnancy with this child normal? \_\_\_\_\_ If "No" please describe: \_\_\_\_\_

Did this child go home at the same time as mom from the hospital? \_\_\_\_\_

Birth weight: \_\_\_\_\_ Current weight: \_\_\_\_\_

Are immunizations up to date? \_\_\_\_\_ If "No" which are missing? \_\_\_\_\_

List all medications the child is taking 1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_ 4. \_\_\_\_\_

List any drug allergies: \_\_\_\_\_

**SOCIAL HISTORY:**

Is the child in school? \_\_\_\_\_ If "Yes" which grade? \_\_\_\_\_

Is the child in daycare? \_\_\_\_\_ If "Yes" how often? \_\_\_\_\_

Is the child exposed to any tobacco smoke? \_\_\_\_\_

Does the child have any of the following?

REVIEW OF SYSTEMS:	NO	YES	REVIEW OF SYSTEMS:	NO	YES
Asthma			Ear infections		
Fevers			Hearing loss		
Easy bleeding/bruising			Kidney disease		
Seizures			Snoring		
Stomach problems			Frequent reflux		

If "Yes" please describe \_\_\_\_\_

**FAMILY HISTORY:**

Do any of the diseases above run in the family? \_\_\_\_\_

Are there any bleeding disorders or "free bleeders" in the family? \_\_\_\_\_

Clinical Use Only: Dr. \_\_\_\_\_ has reviewed the above information with the patient/parent. DATE: \_\_\_\_\_