Pediatric ENT Health History New Patient Form

PROVIDENCE Children's Health

Patient name:_____ Date of birth: _____ □ Male □ Female

Main symptom you would like to discuss today: _____

Symptom length:	□ _____days	□ _____weeks	□ _____months	□_____years
Symptom frequency:	□ sometimes	□ daily	□ always	
Most frequent time of day:	□ upon waking	□ daytime	□ evening	□ after eating
	□ at night	□ random		
Symptoms interfere with:	□ eating	□ sleeping	□ school activities	
Other treatments:	□ Medications: _____			
	□ Food changes: _____			
	□ Other: _____			
Other testing: □ None	□ Blood work	□ Audiology	□ Sleep Studies	□ Imaging

Other symptoms in the past year □ NONE

□ Poor appetite	□ Weight loss or lack of weight gain	□ Cough that won't go away
□ Nausea	□ Chronic or unexplained fevers	□ Wheezing
□ Vomiting	□ Low energy or feeling tired	□ Hoarse voice
□ Trouble swallowing	□ Headaches	□ Chest pain
□ Heartburn	□ Lightheadedness	□ Irregular heart beat
□ Abdominal pain	□ Chills or night sweats	□ Wetting or urine (pee) accidents
□ Burping more than usual	□ Red or painful eyes	□ Painful urination
□ Gas or bloating	□ Mouth sores	□ Back pain
□ Diarrhea	□ Achy joints	□ Feeling dizzy
□ Constipation	□ Red or swollen joints	□ Bleeding or a lot of bruising
□ Painful stools (poop)	□ Hair loss	□ Irregular periods
□ Soiling or stool accidents	□ Rash	□ Anxiety or stress
□ Blood in stool	□ Bigger lymph nodes	□ Depression or feeling mood

Current Medications □ NONE

Medication	Amount	How many times per day?

Medication Allergies and Side Effects □ None

Medication	Reaction

PLEASE FILL OUT THE BACK OF THIS FORM.

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Birth History

How was the baby delivered: □ Vaginal □ Caesarean
When was the baby born: □ At term, 38-42 weeks □ Premature, before 37 weeks:_____
What was the baby's weight at birth: _____
Were there any problems during or after mom gave birth?:_____

Other known health problems □ **None**

Past Surgeries □ **None**

Surgery	Date	Hospital and Surgeon

Past Hospital Stays □ **None**

Reason	Dates	Hospital

Social History

Who lives with the patient?_____
Who cares for the patient during the day?_____
School:_____
How does the patient do in school: Grade in school: □ Average □ Below Average

Activities/Hobbies/Sports:
Pets or animals at home: □ None
Do you suspect your child is involved with: □ Tobacco □ Marijuana □ Sexual Activity □ Other drugs:

Other issues (stresses, divorce, custody, abuse, etc.): _____

Family History

Patient's mother is: □ Alive □ Deceased □ Unknown Occupation: _____
Patient's father is: □ Alive □ Deceased □ Unknown Occupation: _____
How many brothers does the patient have?_____
How many sisters does the patient have? _____

Pediatric ENT

History New Patient Form

Do any of your family members have any of these conditions?	
M = Mother	**F =** Father
S = Sister	**B =** Brother
MGM = Maternal Grandmother	**PGM =** Paternal Grandmother
MGF = Maternal Grandfather	**PGF =** Paternal Grandfather

□ Constipation		□ Rheumatoid Arthritis	
□ Irritable Bowel		□ Juvenile Diabetes	
□ Lactose Intolerance		□ Lupus	
□ Acid Reflux		□ Thyroid disease	
□ Stomach Ulcer		□ Psoriasis	
□ Celiac Disease		□ Migraines	
□ Ulcerative Colitis		□ Seizures	
□ Crohn's Disease		□ Depression	
□ Gallstones		□ Anxiety	
□ Hepatitis B		□ Autism	
□ Hepatitis C		□ Eating Disorder	
□ Other Liver Disease:		□ Other Mental Illness:	
□ Nasal Allergies		□ Adult-Onset Diabetes	
□ Asthma		□ Heart Disease	
□ Eczema		□ High Blood Pressure	
□ Food Allergies		□ High Cholesterol	
□ Anemia		□ Colon Polyps	
□ Tuberculosis		□ Colon Cancer	
□ Problems with Anesthesia		□ Other Cancer:	

Is there anything else we should know about the patient and family?

_____

_____

_____