IOWA ENT CENTER PLLC

PEDIATRIC HISTORY & PHYSICAL

Patient name: _____ **Family physician:** _____

Birth date: _____ /_____ /_____ **Today's date:** _____ /_____ /_____

Current medications: _____

As-needed medications (OTC and vitamins included): _____

Medication allergies: _____ **Non-medication allergies:** _____

Born full term: ☐ Yes ☐ No **NICU stay:** ☐ Yes ☐ No **Born at** _____ **weeks gestation**

Preferred pharmacy: _____ **Current height:** _____ **Current weight:** _____

General history

Previous surgeries: _____

Previous hospitalizations: _____

Behavioral, mental, sensory, or language concerns? ☐ Yes ☐ No If yes, please specify: _____

_____

What can we do or avoid to assist your child during this appointment? _____

_____

Ear history

Newborn hearing screening	☐ Pass	☐ Fail
School/AEA/pediatrician hearing screen	☐ Pass	☐ Fail
Ear infections	☐ Yes	☐ No
Age of onset	_____	
How many antibiotics used	_____	
Medications used	_____	
Previous ear surgery	☐ Yes	☐ No
Concern for hearing loss	☐ Yes	☐ No
Concern for speech delay	☐ Yes	☐ No

Oral/throat history

Recurrent infections/sore throats	☐ Yes	☐ No
Strep swab positive?	☐ Yes	☐ No
How many positive test?	_____	
Snoring	☐ Yes	☐ No
Episodes of paused breathing during sleep	☐ Yes	☐ No
If yes, what is the duration?	_____	
Restless sleeper	☐ Yes	☐ No
Difficulty swallowing food	☐ Yes	☐ No
Choking/gagging while eating	☐ Yes	☐ No
Bad breath	☐ Yes	☐ No

Nasal/sinus history

Congestion	☐ Yes	☐ No
Nasal drainage	☐ Yes	☐ No
Chronic cough	☐ Yes	☐ No
If yes, more often during: ☐ Day ☐ Night		
Headaches	☐ Yes	☐ No
Seasonal allergies	☐ Yes	☐ No
Allergy testing	☐ Yes	☐ No
Eczema	☐ Yes	☐ No
Nosebleeds	☐ Yes	☐ No
If yes, how frequent?	_____	

Airway history

Reactive airway disease/asthma	☐ Yes	☐ No
Describe symptoms: _____		
_____		
Is it improving with time?	☐ Yes	☐ No
Is it worse with feeding?	☐ Yes	☐ No
Is child gaining weight?	☐ Yes	☐ No
Previous chest x-ray	☐ Yes	☐ No
Previous swallow study	☐ Yes	☐ No
Hospitalization(s) related to airway concerns	☐ Yes	☐ No
ER visit(s) related to airway concerns	☐ Yes	☐ No

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Past medical history

Gastrointestinal problems

Fevers/chills/weight loss	☐ Yes	☐ No
Kidney problems	☐ Yes	☐ No
Neurological problems		
Balance issues	☐ Yes	☐ No
Head injury	☐ Yes	☐ No
Seizures	☐ Yes	☐ No
Heart/cardiac problems	☐ Yes	☐ No
History of bleeding disorder	☐ Yes	☐ No

Any other past medical history or medical diagnosis?: _____

_____

Immune/endocrine problems

Abnormal immune studies	☐ Yes	☐ No
Sweat chloride test	☐ Yes	☐ No
HIV/HEP/TB	☐ Yes	☐ No
Family history of immune disorders	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No

Genetic diagnosis ☐ Yes ☐ No

If yes, please specify: _____

_____

_____

Social history

Adopted	☐ Yes	☐ No
Foster care	☐ Yes	☐ No
Secondhand smoke exposure	☐ Yes	☐ No
Attends daycare	☐ Yes	☐ No
In-home or center?	_____	
Breast-fed or bottle-fed as infant	_____	
How long?	_____	
Grade level in school	_____	

Family history

Life-threatening problems with anesthesia	☐ Yes	☐ No
Bleeding disorders	☐ Yes	☐ No
Family history of seasonal allergies	☐ Yes	☐ No

If yes, please explain: _____

_____

Genetic disorders	☐ Yes	☐ No
History of early onset hearing loss	☐ Yes	☐ No
Malignant hyperthermia	☐ Yes	☐ No

Other specialty physicians your child sees (please list physician name and their speciality):

Physician: _____ Specialty: _____

Physician: _____ Specialty: _____

Thank you for taking the time to complete this information for your child.

This is a confidential record of their medical history and will be kept in this office. Information contained here will not be released to any person except when you have authorized us to do so.

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