Randolph Health Ear Nose & Throat
Child Health History Questionnaire

Name _____ Sex F M Date _____

Pharmacy you use _____ Family Doctor _____

Please circle anything child is currently experiencing or having a problem with;

Constitutional
Fevers
Night sweats
Unexplained weight loss

Skin
Dryness
Rash
Skin lesions that are changing

Head, Eyes, Ears, Nose, Throat
Changes in vision
Light sensitivity
Wears glasses or contacts
Hearing loss
Hearing aids
Ringing in ear
Nosebleeds
Nasal congestion
Difficulty breathing through the nose
Loose teeth/toothache
Hoarseness
Wears dentures
Sore throat
Food allergies
Allergies to dust/pollen
Chemical sensitivities (perfume, etc)

Respiratory
Cough
Holding breath/turning blue
Snoring
Shortness of breath
Wheezing

Cardiovascular
Heart murmur

Gastrointestinal
abdominal pain
difficulty swallowing
heartburn
Feeding difficulty

Musculoskeletal
joint pain
joint swelling

Neurological
slurred speech
facial droop
headaches
tremors
weakness in extremities

Psychiatric
anxiety
depression

Endocrine
changes in nails
excessive thirst
excessive urination
changes in hair

Hematology
abnormal bleeding
lumps in neck, groin, armpit

Name_____

Allergies to any medications, if so what is the reaction;

_____

_____

_____

Medications child is currently taking; please list dosage and how taken, if you have them with you skip this question;

_____

_____

_____

_____

_____

_____

Hospitalizations (other than operation) please list, describe, and date;

_____

_____

_____

_____

Does this child attend daycare? Y N

Is this child exposed to tobacco smoke in the home? Y N

Are immunizations up to date? Y N

Has child had any of the following operations;			Date
Ear Tubes	Y	N	_____
Adenoidectomy	Y	N	_____
Tonsillectomy	Y	N	_____
Sinus surgery	Y	N	_____
Hernia repair	Y	N	_____
Appendectomy	Y	N	_____

Other

_____

_____

Please circle any of these child has a history of;

Premature birth	Heart disease	TB (tuberculosis)
If premature birth weight	heart murmur	febrile seizures
Hearing loss	high blood pressure	other seizures
Allergies	hepatitis	meningitis
AIDS/HIV infection	diabetes	attention deficit/hyperactivity
Asthma	thyroid disease	depression
RSV infection	bleeding disorders	cancer (?type) _____
Croup	headaches	other_____

Name_____

Please circle any of the following child's immediate family has a history of;

Premature birth	which family member(s)?_____
Hearing loss	which family member(s)?_____
Allergies	which family member(s)?_____
AIDS/HIV infection	which family member(s)?_____
Asthma	which family member(s)?_____
RSV infection/croup	which family member(s)?_____
Heart disease	which family member(s)?_____
Heart murmur	which family member(s)?_____
High blood pressure	which family member(s)?_____
Hepatitis	which family member(s)?_____
Diabetes	which family member(s)?_____
Thyroid disease	which family member(s)?_____
Bleeding disorders	which family member(s)?_____
Headaches	which family member(s)?_____
Febrile seizures	which family member(s)?_____
Other seizures	which family member(s)?_____
Meningitis	which family member(s)?_____
Attention deficit/hyperactivity	which family member(s)?_____
Depression	which family member(s)?_____
Cancer	which family member(s)?_____

Name of individual completing this form _____

Relationship to the patient: Mother Father other