Children's Hospital of The King's Daughters, Inc.
601 Children's Lane, Norfolk, VA 23507-1910

Pediatric Ear, Nose and Throat
Craig Derkay, M.D. David Darrow, M.D.

PATIENT'S MEDICAL HISTORY

Patient Label or MRN, Patient Name, Patient DOB
(for office use only)

PLEASE TAKE A FEW MOMENTS TO TELL US ABOUT YOUR CHILD'S MEDICAL HISTORY PRIOR TO THEIR INITIAL VISIT WITH US. FILLOUT BOTH SIDES OF THIS FORM AND BRING IT WITH YOU TO YOUR APPOINTMENT. THANK YOU!

Patient's Name: ____
LAST FIRST MIDDLE

Who is your child's primary care physician? ____________________
At which office do you see them? ____________________
Who is referring your child to our practice? ____________________
At which office do you see them? ____________________

For what Ear, Nose and Throat problem(s) are we seeing your child for on this visit? ____________________
____

PLEASE ANSWER THE FOLLOWING QUESTIONS AS THEY APPLY TO YOUR CHILD:

Was your child born ☐ Full Term ☐ Early (premature) # of weeks in womb if premature __________
☐ Vaginal Birth ☐ C-section
Was your child breast-fed? ☐ Yes ☐ No How long? __________

If your child did not come home from the hospital with you, please explain: __________

Has your child ever been hospitalized? ☐ Yes ☐ No If yes, please explain: __________
____

Has your child ever required surgery? ☐ Yes ☐ No If yes, please explain: __________

List ALL OTHER medical problems: ____________________

List all prescription and non-prescription medications your child is taking: __________
____

- Is your child allergic to any medication? ☐ Yes ☐ No If yes, please explain: __________
- Does your child have any environmental allergies? ☐ Yes ☐ No If yes, to what? __________
- Does your child have any food allergies? ☐ Yes ☐ No If yes, to what? __________
- Is your child exposed to anyone who smokes? ☐ Yes ☐ No
- Do you have pets? ☐ Yes ☐ No Type: __________
- Does your child require any of the following special services? ☐ Physical Therapy ☐ Occupational Therapy ☐ Speech Therapy ☐ Special Education ☐ Hearing Impaired ☐ Other: __________
- Do you suspect your child has a hearing problem? ☐ Yes ☐ No
- Has your child's hearing ever been tested? ☐ Yes ☐ No
  If yes, when __________ where __________
  What were the results? __________
- Does your child attend day care or preschool? ☐ Yes ☐ No
  If yes, with how many children? ______ How many day per week? ______ Since what age? ______
  How many days of school, preschool or daycare has your child missed due to illness in the past year? ______

COMPLETE BACK OF PAGE

Does your child have:

Recurrent ear infections	☐ Yes	☐ N0	Age of 1st infection:
	Number of infections in last 12 months:		
	Number of courses of antibiotics in last 12 months:		
Recurrent tonsillitis	☐ Yes	☐ N0	Age of 1st infection:
	Number of infections in last 12 months:		
	Number of infections in last 24 months:		
	Number of infections in last 36 months:		
	Total number of these that were “strep”		
Recurrent sinusitis	☐ Yes	☐ No	
	Number of infections in the past year?		
	Were X-rays taken? ☐ Yes ☐ No		
	When		Where
	☐ CAT Scan		☐ Plain X-rays
Persistent middle ear fluid	☐ Yes	☐ No	Last time it was clear:
	How long present?		
Obstructed breathing problems	☐ Yes	☐ No	☐ snore ☐ mouth breathe ☐ drool ☐ wet the bed ☐ nightmares ☐ restless sleep ☐ croup ☐ fall asleep during the day ☐ morning bad breath ☐ stop breathing at night (Apnea)
If yes, please explain:			
Neck or Facial Mass	☐ Yes	☐ No	When did it first appear?
	Has it changed shape? ☐ Yes ☐ No		Has it changed size? ☐ Yes ☐ No
	Has it changed color? ☐ Yes ☐ No		X-rays been taken? ☐ Yes ☐ No
	Biopsy performed? ☐ Yes ☐ No		

PLEASE CHECK IF ANY OF THE FOLLOWING APPLIES TO YOUR CHILD

	Asthma		Reflux		Seizure disorder
	Blood Disorder		Immune Problems		Birth Defects
	Heart Problems		Kidney Problems		Thyroid Problems
	Diabetes		Skin Problems		Behavior Problems
	Attention Problems		Learning Disability		Developmental Delay
	Speech Delay		Articulation Problem		

PLEASE CHECK IF ANY OF THE FOLLOWING APPLIES TO YOUR FAMILY AND WHICH FAMILY MEMBER

	Bleeding Problems		**Easy Bruising**		**Sickle Cell Disease**
WHO		WHO		WHO	
	HIV Infection		**Middle Ear Infections**		**Ear Tubes**
WHO		WHO		WHO	
	Tonsil or Adenoid Problems		**Sinusitis**		**Hearing Loss**
WHO		WHO		WHO	
	Allergies **Explain:**				

If there are any other medical or psychological problems you think we should be aware of please explain below: _______
____
____

Completed by:____ Date:______________________
Relation to Patient:____

THANK YOU FOR TAKING THE TIME TO FILL OUT THIS FORM.

<u>PLEASE BRING IT WITH YOU TO THE OFFICE</u>