CHESAPEAKE EAR, NOSE & THROAT, P.A.

A Division of THE CENTERS FOR ADVANCED ENT CARE

Pediatric Patient Questionnaire

Date _____

Patient information					
Last Name			First Name		MI
Date of Birth	Age	Sex: M F	Height	Weight	
Names of parents/guardian:			Is the patient a foster child? No ☐ Yes ☐		
Primary care physician: Referring physician:			How did you hear about us?		
Contact info: Please CIRCLE the preferred contact phone number					
Home	Work	Cell	Email		
Preferred Pharmacy Name and Address. Please provide phone number if possible					
What is the nature of the problem that brought you into the office today?					
Medication Allergies: Please list medicine allergies and the reaction.					
NONE☐					
Past Medical History:					
Birth History: Was patient born full term? Yes ☐ No ☐ _____ weeks Vaginal C-section (circle one) Were there any complications with pregnancy or delivery? No ☐ Yes ☐ Please describe:_____ Did they pass the newborn hearing test? Yes ☐ No ☐ For how long was the child breastfed? _____ months/years					
Immunizations: Are Immunizations up to date? Yes ☐ No ☐			**Developmental:** Any developmental delay? No ☐ Yes ☐ Please describe:_____		
Social History:					
Is the patient in daycare? Yes ☐ No ☐ Current grade in school: _____ Is the patient exposed to second hand smoke? Yes ☐ No ☐ Are there pets in the household? No ☐ Yes ☐ Please describe:_____			Are there any siblings? Yes ☐ No ☐ Ages? _____		
Please Circle any of the following conditions the patient has or has had in the past and list any others not below:					
Autism	Asthma	Seizure disorder			
Chronic ear disease	Gastroesophageal reflux (Acid reflux)	Hearing loss			
Chronic sinusitis	Psoriasis/Eczema	Seasonal allergies			
ADHD/ADD	Failure to thrive	Sleep apnea			
Other					
Medications: Please list current medications with dosages and frequency				**NONE**	
Past Surgical History: Please list all surgeries and dates				**NONE**	
	Date			Date	

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Family History: CIRCLE conditions which run in the family (List others not below)		**NONE**
Cardiac (heart) Disease	Asthma or Seasonal Allergies	Bleeding or Clotting Disorder
Diabetes	Cystic Fibrosis	Neurologic disorder
Cancer _____	Hearing Loss	Anesthesia complications
Other:		

Review of Systems: Please CIRCLE all symptoms that the patient has experienced (in the last 3 months)	**NONE**
Constitutional	unexpected weight loss weight gain fever chills fatigue
Eyes	corrective lenses blurry vision double vision eye pain redness watering
ENT	headache difficulty swallowing nose bleeds ringing in ears earaches hearing loss
Cardiovascular	chest pain palpitations fainting murmurs
Respiratory	shortness of breath wheezing cough chest tightness pain with breathing snoring
Gastrointestinal	heartburn nausea vomiting constipation diarrhea bloody/tarry stools
Genitourinary	bedwetting urinary frequency urinary urgency difficult or painful urination bleeding with urination
Musculoskeletal	joint pain swelling stiffness
Skin	skin changes sore that won't heal rash itching redness hives
Hematologic	easy bleeding bruising
Neurological	numbness tingling dizziness unsteady gait
Psychiatric	hyperactivity anxiety depression
Endocrine	excessive thirst heat intolerance cold intolerance
Allergic	reaction to foods or environment
Other (please describe):	

OFFICE USE: Reviewed by							
	Date		Date		Date		Date
	Date		Date		Date		Date