Proliance South Seattle Otolaryngology
Pediatric Patient Health History

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Date ____/____/____

Patient Name _____ DOB _____ Age _____

School _____

Pharmacy Name and Address _____

Medical History/Birth History

Method of deliver? □ Normal □ Cesarean Section

Were there any complications or infections during pregnancy? □ No □ Yes

If yes, please explain: _____

Was your child born premature? □ No □ Yes If yes, list gestational age _____ weeks

Was your child in NICU □ No □ Yes If yes, was child intubated? □ No □ Yes

Did your child pass newborn hearing screening? □ No □ Yes □ Unsure

Was your child breastfed? □ No □ Yes

Please indicate any therapy your child is receiving □ PT □ OT □ Speech □ Other _____

Are your child's immunizations up to date? □ No □ Yes If yes, which ones? _____

Does your child have or ever had any of the following conditions? Please check:

□ Behavior/developmental disorders:
_____

□ Ear infections. If yes, how many in past 12 months:
_____

□ Heart problems:
_____

□ Stomach or intestinal problems:
_____

□ Strep throat or tonsillitis. If yes, how may times in past 12 months:
_____

□ ADHD
□ Asthma
□ Bladder/urinary tract infections (UTIs)
□ Bronchitis/pneumonia
□ Cancer/leukemia
□ CMV exposure
□ Cystic fibrosis
□ Diabetes
□ Headache/migraine
□ Jaundice
□ Meningitis
□ Seizures
□ Thyroid disease
□ Tuberculosis

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Patient Name _____ DOB _____

Do you think your child hears normally? □ No □ Yes
Has anyone voiced concerns about your child's speech development? □ No □ Yes

Please list other medical conditions your child may have:

_____

_____

Previous Surgery

Has your child had any surgeries?
□ No □ Yes (please list below)

Surgeries	Date

Medications

Medication	Dosage	Reason for taking

Family History

Is there a family history (immediate family only) of medical problems? □ No □ Yes

□ Hearing loss
□ Bleeding problems
□ Cancer
□ Diabetes
□ Heart disease
□ High blood pressure
□ Problems with anesthesia
□ Stroke
□ Other _____

Social History

Does your child attend day care? □ No □ Yes
Are there pets in the house? □ No □ Yes
Is there smoke exposure? □ No □ Yes
Who does the child live with? (including siblings): _____

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Patient Name _____ DOB _____

Social History cont'd

School grade? _____ List any special schools or classes _____
Number of languages spoken at home: _____
Do the child's siblings have ear infections? □ No □ Yes
Does the child us a pacifier? □ No □ Yes Stopped using pacifier at age (if applicable): _____
Does the child have poor academic performance? □ No □ Yes