

**Washington University School of Medicine in St. Louis  
Pediatric Otolaryngology**

NAME: \_\_\_\_\_

VISIT DATE: \_\_\_/\_\_\_/\_\_\_ BIRTHDATE \_\_\_/\_\_\_/\_\_\_ SEX: Male Female

What is the **Main Reason** for your child's visit today? \_\_\_\_\_

How long has this problem existed? \_\_\_\_\_

Have you seen any of our providers before, for this child or another family member? \_\_\_\_\_

Hirose\_\_\_ Lieu\_\_\_ Molter\_\_\_ Hullar\_\_\_ Ogden\_\_\_ Massmann\_\_\_ Wambold\_\_\_

**EARS, NOSE AND THROAT HISTORY:** Circle all that apply;

Hearing problems	Snoring
Extensive treatment with antibiotics	Mouth breathing
Ear infections # in 6 mos___ , 1 yr. ___	Tongue tie
Head trauma	Frequent sore throats
Cough	Strep throats, # in this yr___ #2 yrs ago___
Enlarged glands	Difficulty swallowing
Noisy breathing	Difficulty with speech
Hoarseness	Sores/ulcers in mouth
Sinus infections	Nasal discharge

**PREVIOUS TESTS PERFORMED:**

Allergy testing	Y N	Hearing test	Y N
Sweat test	Y N	Genetic test	Y N
X-rays, CT, MRI	Y N	Immune test	Y N

**BIRTH HISTORY:**

Birth Weight: \_\_\_ lbs. \_\_\_ ozs.

Premature? Y N How many weeks? \_\_\_\_\_ NICU stay? Y N

Newborn hearing screen results were: Pass\_\_\_ Fail\_\_\_ Never tested\_\_\_

**DEVELOPMENTAL HISTORY:**

Speech Delay? Y N Gross Motor Delay? Y N Learning Disabilities? Y N

**PAST MEDICAL HISTORY:**

Abnormal Development	Y N	Heart Disease	Y N
Arthritis	Y N	Hemophilia/ Sickle Cell	Y N
Asthma/Respiratory	Y N	Immune Deficiency	Y N
Attention Deficit Disorder	Y N	Muscle/Bone disorders	Y N
Bleeding Disorders	Y N	Neurological Disorders	Y N
Cerebral Palsy	Y N	Seizures/Shunt	Y N
Cystic Fibrosis	Y N	Skin rashes	Y N
Diabetes	Y N	Thyroid Disorders	Y N
Downs Syndrome	Y N	Urinary/Kidney Disorders	Y N
Gastrointestinal/ Reflux Disorders	Y N		
Other:	_____		

**PAST HOSPITALIZATIONS:** List reasons and dates of admission.

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**SURGICAL HISTORY:** List procedure, dates, surgeon.

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**FAMILY HISTORY:** Circle all that apply for brothers, sisters, parents, grandparents

Problems with anesthesia	Stroke	Heart Disease
Problems with bleeding	Psychiatric Illness	Kidney Disease
Cancer	Hearing Loss	Sudden death
Diabetes	Unknown history, child adopted	
High Blood Pressure	Allergies/Asthma	

**MEDICATIONS:** Please list name, strength, how often taken.

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**ALLERGIES TO MEDICATIONS:** List drug name and reaction(rash, swelling, shock)

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**IMMUNIZATIONS:** Up to date, Delayed, Reason for delay? \_\_\_\_\_

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**SOCIAL HISTORY:** Circle all that apply.

Who has legal custody of Child? Both Parents, Mom, Dad, Grandparents, Other.  
Child lives with: Both Parents, Mom, Dad, Grandparents, Other family/relatives, Foster family  
Parents are: Married, Not married, Separated, Divorced  
Does your child attend: Daycare Preschool Grade in school? \_\_\_\_\_  
Number of brother/sisters: \_\_\_\_\_  
Pets in the home? Dog Cat Other \_\_\_\_\_  
Smokers in the house, even if they do not smoke inside? No Yes

**Reviewed by:** \_\_\_\_\_, RN / MD