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____ Leonard____ Menezes____ Ogden____ Dunsky____
Drescher____ Chole____ Buchman____

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___ Refer___ 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.

_____
_____

SURGICAL HISTORY: List procedure, dates, surgeon.

_____
_____

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.

_____
_____

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

_____
_____

IMMUNIZATIONS: Up to date, Delayed, Reason for delay? _____
_____

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

PHOTOGRAPHIC CONSENT: Permission for Photography and Release.
I hereby voluntarily grant permission to the Doctors of the Division of Otolaryngology at St. Louis Children's Hospital and her/his designated representatives to take and use clinical photographs of my child(ren) with the understanding that such photographs are for confidential, clinical record purposes, and that all photographs remain the property of the doctor. Occasionally, such photographs are used for teaching purposes, research, medical publications, medical as well as public educations, and for patient information and education. If your child's photograph is used for publication, you will be notified BEFORE any publication is produced. Otherwise, photographs are for our records only.

X_____ _____
Signature of patient / parent / legal guardian **Date**

Reviewed by: _____, RN / MD

Rev. 7/18/17