Associates in Otolaryngology
Pediatric Health History Form

Today's Date:_____ Patient Name:_____DOB:_____

Social History

Alcohol:	O Yes O No	Daycare:	O Yes O No
Chewing tobacco	O Yes O No	Exercise:	O Yes O No
Smoking:	O Yes O No	Pets:	O Yes O No
Recreational drug use:	O Yes O No	Passive smoke exposure:	O Yes O No
Parents married:	O Yes O No	Sexually Active:	O Yes O No
Student:	O Yes O No		

ENT

discharge from ears	O Yes O No
ear infections	O Yes O No
ear pain	O Yes O No
concerns about hearing	O Yes O No
concerns about speech delay	O Yes O No
persistent stuffy nose	O Yes O No
prior nasal injury	O Yes O No
nosebleeds	O Yes O No
runny nose	O Yes O No
snoring	O Yes O No
difficulty swallowing	O Yes O No
hoarseness	O Yes O No

ALLERGY

sneezing	O Yes O No
itchy eyes	O Yes O No
eczema	O Yes O No
asthma	O Yes O No

CONSTITUTIONAL

weight gain	O Yes O No
fever	O Yes O No
weight loss	O Yes O No
fatigue	O Yes O No
breast feeding	O Yes O No
walking	O Yes O No

CARDIOLOGY

palpitations	O Yes O No
turns blue	O Yes O No
high blood pressure	O Yes O No
heart murmur	O Yes O No

GASTROENTEROLOGY

vomiting/nausea	O Yes O No
diarrhea	O Yes O No
constipation	O Yes O No
jaundice	O Yes O No
abdominal pain	O Yes O No

DERMATOLOGY

rash	O Yes O No
skin lesion change	O Yes O No
acne	O Yes O No

HEMATOLOGY/LYMPH

easy bruising/bleeding	O Yes O No
anemia	O Yes O No

ENDOCRINOLOGY

swollen glands	O Yes O No
excessive thirst	O Yes O No
diabetes	O Yes O No
thyroid problems	O Yes O No

MUSCULOSKELETAL

joint stiffness/pain	O Yes O No
joint swelling	O Yes O No
leg cramps	O Yes O No

NEUROLOGY

headaches	O Yes O No
dizziness	O Yes O No
seizures	O Yes O No

OPTHALMOLOGY

vision changes	O Yes O No
drainage from eyes	O Yes O No
swelling/pain around eye	O Yes O No

RESPIRATORY

trouble breathing	O Yes O No
cough	O Yes O No
wheezing	O Yes O No
bronchitis	O Yes O No

PSYCHOLOGY

attention deficit	O Yes O No
mood disorder	O Yes O No
mental or physical abuse	O Yes O No
anxiety	O Yes O No
depression	O Yes O No

GENITOURINARY

urinary tract infections	O Yes O No
frequent or pain with urination	O Yes O No
discharge	O Yes O No
blood in urine	O Yes O No

Associates in Otolaryngology
Adult Patient Health History Form

Today's Date:_____ Patient Name:_____DOB:_____

Social History

Alcohol:	O Yes O No	Caffeine:	O Yes O No
Chewing tobacco	O Yes O No	Exercise:	O Yes O No
Smoking:	O Yes O No	Pets:	O Yes O No
Recreational drug use:	O Yes O No	Passive smoke exp:	O Yes O No
Married:	O Yes O No		

Occupation: O attorney O physician O engineer O teacher O computer/IT O construction/factory
O retail O student O retired O other

PSYCHOLOGY

suicidal thoughts	O Yes O No
mood disorder	O Yes O No
mental or physical abuse	O Yes O No
anxiety	O Yes O No
depression	O Yes O No

MUSCULOSKELETAL

joint stiffness	O Yes O No
leg cramps	O Yes O No
joint pain	O Yes O No
joint swelling	O Yes O No
back pain	O Yes O No

CONSTITUTIONAL

fever	O Yes O No
fatigue	O Yes O No
weight gain	O Yes O No
weight loss	O Yes O No

CARDIOLOGY

palpitations	O Yes O No
swelling of legs/ankles	O Yes O No
difficulty breathing	O Yes O No
high blood pressure	O Yes O No
heart murmur	O Yes O No
chest pain/angina	O Yes O No

GASTROENTEROLOGY

diarrhea	O Yes O No
constipation	O Yes O No
vomiting	O Yes O No
nausea	O Yes O No
difficulty swallowing	O Yes O No
heartburn	O Yes O No
hoarseness	O Yes O No

DERMATOLOGY

rash	O Yes O No
skin lesion change	O Yes O No
skin cancer	O Yes O No

ENDOCRINOLOGY

fatigue	O Yes O No
excessive thirst	O Yes O No
frequent urination	O Yes O No
sleep disturbance	O Yes O No
cold intolerance	O Yes O No
heat intolerance	O Yes O No
diabetes	O Yes O No
thyroid problems	O Yes O No

NEUROLOGY

headaches	O Yes O No
dizziness	O Yes O No
seizures	O Yes O No
insomnia (difficulty sleeping)	O Yes O No
memory loss	O Yes O No
face weakness	O Yes O No
difficulty walking	O Yes O No

OPTHALMOLOGY

diminished vision	O Yes O No
drainage from eyes	O Yes O No
blurring of vision	O Yes O No
loss of vision	O Yes O No
swelling/pain around eye	O Yes O No

RESPIRATORY

Difficulty breathing	O Yes O No
cough	O Yes O No
wheezing	O Yes O No
coughing up blood	O Yes O No

ALLERGY

sneezing	O Yes O No
itchy eyes	O Yes O No
eczema	O Yes O No
asthma	O Yes O No

HEMATOLOGY/LYMPH

easy bruising/bleeding	O Yes O No
anemia	O Yes O No