WELLSTONE EAR, NOSE & THROAT
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PEDIATRIC HEALTH HISTORY QUESTIONNAIRE

Patient Name: ____ Date: ________________

Parent Name(s): ____

What problem can we help with today? ____

Who is your child's doctor? ______________________________________ ❑ **No Primary Doctor**

BIRTH HISTORY		
Any mother's health problems during pregnancy?	❑ Yes	❑ No
Any complications with the delivery?	❑ Yes	❑ No
Was your child born full term?	❑ Yes	❑ No
What was the method of delivery?	❑ Vaginal	❑ C-section
Did they spend any time in a NICU?	❑ Yes	❑ No

PAST MEDICAL HISTORY			
❑ **NO MEDICAL PROBLEMS** ❑ Other ______________________________			
Are all of your child's immunizations up to date? ❑ Yes ❑ No ❑ Unsure			
Problem	**Type/Comment**	**Problem**	**Type/Comment**
❑ Acid Reflux/GERD		❑ Hayfever (Allergies)	
❑ Anemia		❑ Head Injury	
❑ Asthma		❑ Migraines	
❑ Bleeding Disorder		❑ Sleep Apnea	
❑ Cancer			
❑ Diabetes			

PAST SURGICAL HISTORY		
❑ **NO PREVIOUS SURGERIES**		
Year	Type	Hospital

*Additional sheet for listing surgeries available at the front desk

FAMILY HISTORY		
❑ Allergies	❑ Cancer: ___________________	❑ Migraines
❑ Anesthesia problems	❑ Diabetes	❑ Seizures
❑ Asthma	❑ Hearing Loss (before 50)	❑ Stroke
❑ Bleeding Disorder	❑ Heart Disease	❑ Other:

PRESCRIBED DRUGS, OVER-THE-COUNTER DRUGS, HERBALS, AND SUPPLEMENTS		
Medication Name	Strength	Frequency Taken

*Additional sheet for listing medications and/or allergies available at the front desk

MEDICATION AND FOOD ALLERGIES				
❑ **No Medication Allergies**		❑ Latex Allergy		❑ Iodine (Shellfish) Allergy
Medication/Food	Type of Reaction		Medication/Food	Type of Reaction

SOCIAL HISTORY		
Occupation	What grade is your child in?	Do they listen to loud music? ❑ Yes ❑ No
Other	Is your child exposed to tobacco smoke (secondhand)? ❑ Yes ❑ No	

CURRENT SYMPTOMS (PLEASE CIRCLE) OR ❑ NO SYMPTOMS			
Constitutional/General	Difficulty Swallowing	Nausea	**Endocrine**
Fatigue	Snoring	Vomiting	Heat Intolerance
Fevers	Sore Throat	**Genitourinary**	Cold Intolerance
Night Sweats	Hoarseness	Frequent Urination	**Psychological**
Weight Loss	Sores/Ulcers In Mouth	Genital Ulcers	Anxiety
Weight Gain	Neck Swelling/Lump	**Skin**	Panic Attacks
Eyes	**Cardiovascular**	Itchy Skin	Depression
Double Vision	Chest Pain	Ulcers	Suicidal Thoughts
Dry Eyes	Blacking Out / Fainting	Rash	**Hematological/Lymphatic**
Vision Change	Swelling Of Ankles/Feet	**Neurological**	Easy Bleeding
Ear, Nose, Mouth, Throat	**Respiratory**	Headache	Bruising
Hearing Loss	Cough	Seizures	Heavy Periods (if female)
Ear Infections	Shortness of Breath	Falling	**Allergic/Immunological**
Dizziness	Wheezing	Numbness	Eczema
Ear Pain	**Gastrointestinal**	Weakness	Itchy Eyes
Ringing /Noise In Ears	Constipation	**Musculoskeletal**	Runny Nose
Nasal Congestion	Diarrhea	Jaw Popping / Grinding	Sneezing
Nose Bleeds	Heartburn	Neck Pain or Injury	Urticaria / Hives

Office Use Only

Reviewed by MD: ____ **Date:** ________________________