Ear, Nose & Throat
SPECIALISTS OF ILLINOIS

Pediatric
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PATIENT MEDICAL HISTORY FORM

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

Please list the name(s) of your doctor(s):

Physician Name: _____ Physician Name: _____

Address: _____ Address: _____

Phone: _____ Phone: _____

Fax #: _____ Fax #: _____

Is there a family history of hearing loss? ☐ YES ☐ NO

Have you ever had an audiogram (hearing test)? ☐ YES ☐ NO

If you wear a HEARING AID, where did you purchase it/them? _____

List all allergies to medications:

_____

List all medications you take: Including over-the-counter medications, vitamins or herbal supplements:

_____

_____

_____

Do you smoke? ☐ YES ☐ NO

If yes, how much? _____

Do you drink? ☐ YES ☐ NO

If yes, how much? _____

Height: _____ Weight: _____

Do you or any of your family members have the following illnesses?

Diabetes	☐ Self	☐ Mother	☐ Father	☐ Bro	☐ Sis
Bleeding Problems	☐ Self	☐ Mother	☐ Father	☐ Bro	☐ Sis
Heart Disease	☐ Self	☐ Mother	☐ Father	☐ Bro	☐ Sis
Anesthesia Problems	☐ Self	☐ Mother	☐ Father	☐ Bro	☐ Sis
High Blood Pressure	☐ Self	☐ Mother	☐ Father	☐ Bro	☐ Sis
Kidney Disease	☐ Self	☐ Mother	☐ Father	☐ Bro	☐ Sis
Lung/Asthma	☐ Self	☐ Mother	☐ Father	☐ Bro	☐ Sis
Dementia/Alzheimer's	☐ Self	☐ Mother	☐ Father	☐ Bro	☐ Sis

Stroke	☐ Self	☐ Mother	☐ Father	☐ Bro	☐ Sis
Hearing Loss	☐ Self	☐ Mother	☐ Father	☐ Bro	☐ Sis
Thyroid	☐ Self	☐ Mother	☐ Father	☐ Bro	☐ Sis
Cancer	☐ Self	☐ Mother	☐ Father	☐ Bro	☐ Sis

Type of Cancer: _____

AIDS/HIV ☐ Self ☐ YES ☐ NO

HEPATITIS C ☐ Self ☐ YES ☐ NO

Other: _____

List past surgeries/Hospitalizations:

☐ No Past Surgeries/Hospitalizations

REVIEW OF SYSTEMS—*Are you currently having any of the following problems? (Please check)*

Eyes
☐ Dry or itchy eyes
☐ Decreased vision

Ears
☐ Ringing or noise in the ears
☐ Ear pain or drainage
☐ Hearing loss

Nose
☐ Blocked or runny nose
☐ Loss of smell
☐ Nosebleeds

Throat
☐ Difficulty swallowing
☐ Painful swallowing
☐ Hoarse/Rough voice
☐ Frequent throat-clearing

Heart
☐ Chest pain with activity
☐ Irregular heartbeat

Lungs
☐ Chronic cough
☐ Coughing up blood
☐ Shortness of breath
☐ Asthma

Stomach
☐ Heartburn
☐ Stomach pain
☐ Nausea or vomiting
☐ Bloody stools

Bones and Muscle
☐ Arthritis
☐ Muscle pain

Skin
☐ Changes in mole or wart
☐ New skin growth

Neuro
☐ Change in facial muscle strength
☐ Loss of facial sensation
☐ Headaches

Allergy/Immuno
☐ Seasonal allergies

General
☐ Fever greater than 99 degrees
☐ Unexplained weight loss
☐ Fatigue/Weakness