

Patient Name: _____ **Age:** _____ **Date:** _____

Sex: M or F _____ **Weight:** _____

CC: For what problem is your child being evaluated? _____

Date started: _____

Total number of infections or episodes? _____

Last infection or episodes: _____

Symptoms: (Circle current symptoms)

Fussy, irritable, pain, poor sleeping, decreased appetite, others; _____

Signs: (Circle if applicable)

Fever, drainage, perforation in eardrum

Treatment: (Circle antibiotics prescribed)

Amoxicillin, Augmentin, Ceftin, Cefzil, Omnicef, Zithromax, Rocephin Injection,

Other medications: _____

Risk Factors:

Daycare: Yes or No _____ Number of children in class? _____

Exposed to second hand smoke: Yes or No _____

Number of siblings: _____ Ages: _____ Siblings history of ear infections: Yes or No _____

Parent's history of ear disease: _____

Other Medical History: (Yes or No)

Previous tubes: _____ Tonsil/adenoids removed: _____

Cardiac problems: _____ Respiratory problems: _____

Other Surgeries or problems: _____

Birth History:

Full term: _____ Weeks of Gestation: _____

Vaginal or C-Section: _____ Complications: _____

Admitted to NICU? _____ For how long? _____

Were they placed on a ventilator? _____ Oxygen? _____

Did they pass their newborn hearing screen? _____

Did they have yellow jaundice? _____ Were they treated with lights? _____

Any genetic problems or syndromes? _____

Allergies:

What medications are they allergic to? _____

Any food allergies? _____ Any seasonal allergies? _____

Other _____

Speech and Language:

Responding to sounds: Yes or No _____ Babbling: Yes or No _____

Number of words: _____ Putting two words together: Yes or No _____

Speaking in sentences: Yes or No _____

Can you understand them clearly: Yes or No _____

Anesthesia History:

List any family history of anesthesia problems: _____

Fevers during anesthesia: Yes or No _____ Prolonged wake-up time: Yes or No _____

Nausea or Vomiting: Yes or No _____ Other problems with anesthesia: _____

American Indian Heritage? Yes or No _____

Bleeding Disorders: (circle if applicable)

Family history of: Hemophilia, Sickle Cell Anemia, Anemia, easy bruising,
easy bleeding, others: _____

