

THE EAR CENTER OF GREENSBORO, P.A. / SU WOOL TEOH M.D.,P.A

History Form - Children 12 & Under

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: \_\_\_\_\_