Buffalo Otolaryngology Group, P.C. - PEDIATRIC HISTORY

Patient Name:___________________________

What ear, nose or throat problem brought your child to our office today?

LIST CHILD'S ALLERGIES:

MEDICATIONS CHILD IS TAKING:

CHILD'S PAST SURGERIES:

Height ________ Weight

Birth Weight

Was your child premature?

If so, how many months?

List any diseases the mother had during pregnancy:

Other pertinent birth history:

Does your child have or had any of the following conditions?

1)	Diabetes	Yes	No
2)	Cancer If yes, where	Yes	No
3)	Bladder problems	Yes	No
4)	Blood disorders	Yes	No
5)	Heart problems, lung problems, asthma?	Yes	No
6)	Asthma	Yes	No
7)	Other:		

For Office Use Only: UPDATED HISTORIES	
Date	Initials

Is there a family history of:

Tuberculosis	Yes	No	Who?
Cancer (specify type)	Yes	No	Who?
Diabetes	Yes	No	Who?
High blood pressure	Yes	No	Who?
Heart disease	Yes	No	Who?

Is there any reason the child cannot have blood transfusions? Yes No

Does anyone in the child's household smoke? Yes No

Has your child had prolonged anti-biotic or diuretic treatment? Yes No
Please explain:

Is there a family history of hearing loss? Yes No
Please list who and explain:

List childhood diseases your child has had?

I have read the above questions and have completed them truthfully and to the best of my ability.

Signature of Patient/Parent/Guardian

Date

Witness