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 Yes No
   If yes, where
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?

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

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