CHILDREN'S
HEALTH SYSTEM®
1600 7th Avenue South
Birmingham, AL 35233

ENT HISTORY FORM

Patient Nickname: _____
Telephone # _____ Alternate # _____

1. **Chief Complaint:**
   Why are you bringing your child to see us today? _____
   _____

2. **History of Present Illness:**
   When did this problem begin? _____
   Is there anything that makes the problem worse or better? _____
   How often has the problem occurred in the last six months? _____
   What are your child's symptoms? _____
   What treatment has your child had for this problem? _____
   Has your child had any of the following tests for this problem? Please circle if yes.

   Allergy Testing Immunotherapy X-rays Cat Scan Sweat Test MRI

   Date: _____ Where? _____

3. **Past Medical History:**
   Immunizations up to date? _____
   Any allergies to drugs or latex? If yes, please list _____
   Any other medical problems? If yes, please list _____
   Any hospitalizations? If yes, please list most recent, where and why. _____
   _____
   First day of last menstrual period. _____

4. **Past Surgical History:**
   Please list any previous surgical procedures.
   _____ Date: _____
   _____ Date: _____

5. **Medications:**
   Please list any medications (prescriptive and non-prescriptive) your child is currently taking.
   _____
   _____

6. **Family History / Social History:**
   Does anyone in the family have a history of any of the following problems? If yes, who?
   Allergies_____
   Hearing or ear problems_____
   Anesthesia reactions other than nausea: _____
   Bleeding disorders_____
   Muscular Dystrophy_____
   Does anyone in your household smoke? _____ Is your child in daycare? _____
   Who is your child's primary caretaker? _____
   Does your child have any siblings? _____
   Religious preference _____

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REVIEW OF SYSTEMS: Please check the boxes that apply to conditions that the patient may have.

1. General/Constitutional
   - □ Fever
   - □ Weight Loss
   - □ Fatigue
   - □ Other: _____

2. Eyes
   - □ Glasses
   - □ Contacts
   - □ Color Blind
   - □ Blind
   - □ Other: _____

3. Ears/Nose/Throat
   - □ Runny Nose
   - □ Snoring
   - □ Decreased Hearing
   - □ Deafness
   - □ Ringing in Ears
   - □ Seasonal Allergies
   - □ Loose Teeth
   - □ Tracheostomy
   - □ Nosebleeds
   - □ Speech Problems
   - □ Hearing Aid
   - □ Ear Drainage
   - □ Nasal Congestion
   - □ Ear Tubes
   - □ Noisy Breathing
   - □ Birthmarks
   - □ Skin Tags
   - □ Other: _____

4. Respiratory
   - □ Shortness of Breath
   - □ Asthma
   - □ Cough
   - □ Frequent Pneumonia
   - □ Tuberculosis
   - □ Noisy Breathing
   - □ Other: _____

5. Cardiovascular
   - □ Irregular Heartbeat
   - □ Fainting
   - □ Rheumatic Fever
   - □ Heart Defect
   - □ Swelling of Extremities
   - □ Other: _____

6. Gastrointestinal
   - □ Gastroesophageal Reflux
   - □ Vomiting
   - □ Stomach Ulcers
   - □ Diarrhea
   - □ Problems Swallowing
   - □ Weight Gain
   - □ Weight Loss
   - □ Other: _____

7. Genitourinary
   - □ Recurrent Bladder Infection
   - □ Kidney Disease
   - □ Blood in Urine
   - □ Other: _____

8. Neurologic
   - □ Dizziness
   - □ Frequent Headaches
   - □ Migraines
   - □ Problems with Walking
   - □ Seizures
   - □ Paralysis
   - □ Weakness
   - □ Visual Changes
   - □ Other: _____

9. Skin
   - □ Rash
   - □ Dermatitis
   - □ Ulcers
   - □ Excessive Bruising
   - □ Birthmarks
   - □ Other: _____

10. Musculoskeletal
   - □ Bone Infections
   - □ Weakness
   - □ Muscle Cramps
   - □ Broken Bones
   - □ Chronic Bone or Muscle Pain
   - □ Other: _____

11. Endocrine
   - □ Diabetes
   - □ Hepatitis
   - □ Liver Disease
   - □ Jaundice
   - □ Other: _____

12. Blood and Immune Disorders
   - □ Hodgkins Disease
   - □ Lymphoma
   - □ Sickle Cell Disease
   - □ Sickle Cell Trait
   - □ Leukemia
   - □ HIV Positive
   - □ AIDS
   - □ Cancer
   - □ Other Immune Disorders _____

13. Psychological
   - □ Depressed
   - □ Mood Swings
   - □ Other: _____

14. Birth Defects

Please list any birth defects

_____

_____

_____

_____

Completed by:

_____

Relationship to child:

_____

I have received the above information with the person completing the form and / or presenting the patient for treatment.

Signature: _____
(Physician)

Date: _____