THE UNIVERSITY OF ARIZONA MEDICAL CENTER
University Campus

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3300

MEDICAL RECORD#
DOB
NAME
VISIT#

# PEDIATRIC OTOLOGY
# PATIENT INITIAL VISIT

Please provide the following information to the best of your ability:

**What problem(s) are you here for today?** _____

_____

**PAST MEDICAL HISTORY / BIRTH HISTORY:**

1) PLEASE ANSWER THE FOLLOWING:

**WHAT WAS THE CHILD'S GESTATIONAL AGE AT DELIVERY:** _____ WEEKS **BIRTH WEIGHT:** _____

**METHOD OF DELIVERY:** ☐ VAGINAL ☐ CAESAREAN SECTION ☐ OTHER _____

**WAS A NEWBORN HEARING TEST PERFORMED?** ☐ YES ☐ NO RESULTS: _____

2) PLEASE CHECK THE "YES" OR "NO" BOX TO INDICATE IF PATIENT HAS / HAD ANY OF THE FOLLOWING ILLNESSES: FOR "YES" ANSWERS, PLEASE EXPLAIN:

| | YES | NO | | YES | NO | |
|---|---|---|---|---|---|---|
| **INFECTIONS DURING PREGNANCY** | ❑ | ❑ | **KIDNEY PROBLEMS** | ❑ | ❑ | |
| **COMPLICATION DURING PREGNANCY** | ❑ | ❑ | **NEUROLOGICAL PROBLEMS** | ❑ | ❑ | |
| **HEART PROBLEMS** | ❑ | ❑ | **IMMUNE DEFICIENCY** | ❑ | ❑ | |
| **BLEEDING DISORDER** | ❑ | ❑ | **ALLERGY PROBLEMS/THERAPY** | ❑ | ❑ | |
| **RESPIRATORY PROBLEMS** | ❑ | ❑ | **IMMUNIZATIONS UP TO DATE** | ❑ | ❑ | |
| **SIGNIFICANT INJURY (IES)** | ❑ | ❑ | **OTHER MEDICAL PROBLEMS** | ❑ | ❑ | |

_____

_____

_____

3) PLEASE LIST ANY SURGERIES OR HOSPITALIZATIONS (AND DATES) YOU HAVE EVER HAD (INCLUDING TONSILS & ADENOIDS):

| SURGERIES/HOSPITALIZATIONS | YEAR | SURGERIES/HOSPITALIZATIONS | YEAR |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

**ANESTHESIA PROBLEMS:** ☐ **YES** ☐ **NO** _____

4A) PLEASE LIST ALL CURRENT MEDICATIONS (INCLUDING DOSAGE AND TIMES PER DAY): **PLEASE INCLUDE OVER-THE COUNTER MEDICATIONS**

| MEDICATION | DOSE | FREQUENCY | MEDICATION | DOSE | FREQUENCY |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |

4B) LIST ANY **ALLERGIES** TO MEDICATIONS:

5) PLEASE INDICATE ANY SPECIAL THERAPY (IES): ☐ SPEECH THERAPY ☐ PHYSICAL THERAPY ☐ OCCUPATIONAL THERAPY ☐ OTHER

_____

_____

_____

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## SOCIAL HISTORY:

**DOES THE CHILD ATTEND DAY CARE?** ☐ YES ☐ NO **SCHOOL GRADE:** _____ **HEARING IMPAIRED CLASSES:** ☐ YES ☐ NO

**WITH WHOM DOES THE CHILD LIVE?** _____

**IS THE CHILD EXPOSED TO CIGARETTE SMOKE?** ☐ YES ☐ NO

**CAFFEINE INTAKE:** _____ PER DAY **EXERCISE:** ☐ YES ☐ NO **TYPE/FREQUENCY:** _____

## FAMILY HISTORY:

1) PLEASE CHECK THE "YES" OR "NO" BOX TO INDICATE WHETHER ANY RELATIVES HAVE ANY OF THE FOLLOWING ILLNESSES/PROBLEMS:

2) FOR "YES" ANSWERS, PLEASE INDICATE WHICH RELATIVE(S) HAS/HAVE THE PROBLEM AND EXPLAIN

| | YES | NO | |
|---|---|---|---|
| **HEARING LOSS** | ☐ | ☐ | _____ |
| **BLEEDING DISORDER** | ☐ | ☐ | _____ |
| **CANCER** | ☐ | ☐ | _____ |
| **HEART DISEASE** | ☐ | ☐ | _____ |
| **DIABETES** | ☐ | ☐ | _____ |
| **ANESTHESIA PROBLEMS** | ☐ | ☐ | _____ |
| **OTHER MEDICAL PROBLEMS** | ☐ | ☐ | _____ |

_____

## REVIEW OF SYSTEMS:

1) Please check the "Yes" or "No" box to indicate whether the patient has any of the following symptoms:

2) For any "Yes" answers, please check the "Current" box if this symptom relates to the reason for your visit today

| | | Yes | No | Current | | Yes | No | Current |
|---|---|---|---|---|---|---|---|---|
| GENERAL | Fever | ☐ | ☐ | ☐ | Weight loss ☐ or gain ☐ | ☐ | ☐ | ☐ |
| EYES | Wear glasses | ☐ | ☐ | ☐ | Injuries/Trauma | ☐ | ☐ | ☐ |
| CARDIOVASCULAR | Swelling of feet | ☐ | ☐ | ☐ | Irregular pulse | ☐ | ☐ | ☐ |
| RESPIRATORY | Chronic cough | ☐ | ☐ | ☐ | Noisy breathing | ☐ | ☐ | ☐ |
| NEUROLOGICAL | Fainting | ☐ | ☐ | ☐ | Chronic headache | ☐ | ☐ | ☐ |
| PSYCHIATRIC | Depression | ☐ | ☐ | ☐ | Anxiety | ☐ | ☐ | ☐ |
| | Schizophrenia | ☐ | ☐ | ☐ | Manic/Depression | ☐ | ☐ | ☐ |
| SKIN | Rash | ☐ | ☐ | ☐ | Itching | ☐ | ☐ | ☐ |
| | Hives | ☐ | ☐ | ☐ | Birth marks | ☐ | ☐ | ☐ |
| MUSCULOSKELETAL | Joint pain | ☐ | ☐ | ☐ | Muscle pain | ☐ | ☐ | ☐ |
| GI | Nausea | ☐ | ☐ | ☐ | Vomiting | ☐ | ☐ | ☐ |
| ENDOCRINE | Excessive thirst | ☐ | ☐ | ☐ | Feel warmer than others | ☐ | ☐ | ☐ |
| | | | | | Feel cooler than others | ☐ | ☐ | ☐ |
| HEME/LYMPH | Swollen glands | ☐ | ☐ | ☐ | Bleeding problems | ☐ | ☐ | ☐ |
| ALLERGY | Food allergies | ☐ | ☐ | ☐ | Inhalant allergies | ☐ | ☐ | ☐ |
| ENT | Ear pain | ☐ | ☐ | ☐ | Ear drainage | ☐ | ☐ | ☐ |
| | Ear pressure | ☐ | ☐ | ☐ | Recurrent ear infections | ☐ | ☐ | ☐ |
| | Hearing loss | ☐ | ☐ | ☐ | Tinnitus/Ear noises | ☐ | ☐ | ☐ |
| | Imbalance | ☐ | ☐ | ☐ | Vertigo / Spinning | ☐ | ☐ | ☐ |
| | Hoarseness | ☐ | ☐ | ☐ | Sore throat | ☐ | ☐ | ☐ |
| | Snoring with pauses | ☐ | ☐ | ☐ | Recurrent throat infections | ☐ | ☐ | ☐ |
| | Nasal congestion | ☐ | ☐ | ☐ | Wear hearing aid (s) | ☐ | ☐ | ☐ |

_____

_____

Reviewed by: _____ Date: _____ Military Time: _____