Coastal Ear, Nose and Throat 1520 Highway 138 Wall, NJ 07719

Health Questionnaire

Patient: _____ DOB: _____ Age: _____ Date: _____

Reason for Visit: _____

Medications: **Please list your child's current medications, including non-prescription. . Include the name of the medication, and the strength. (For example, Digoxin .0125 mg.)**

Drug Allergies: **Please list any drug allergies, including reactions. Please state NONE if no allergies.**

Non-Drug Allergies: **Please list any food or non-drug allergies, including reactions. State NONE if no allergies.**

Past Illnesses **Please circle Y or N if your child has had any illnesses in the past.**

Anemia	Y	N	Diabetes I	Y	N	**Eczema**	Y	N	Pneumonia	Y	N
Asthma	Y	N	Diabetes II	Y	N	**Hay Fever/Allergies**	Y	N	Psoriasis	Y	N
Bronchitis	Y	N				**Heart murmur**	Y	N	Seizures	Y	N

Recurrent episodes of: (Circle) Ear infections Tonsillitis Strep Throat

Cancer Y N _____ _____ _____ _____ _____

Chicken Pox Y N Measles Y N Mumps Y N Scarlet fever Y N Rheumatic fever Y N

Height: _____' _____ Weight: _____ Lbs

Previous Surgeries **Please list any past surgeries.**

Surgery	Year

Birth Record

Birth length: _____ Inches

Birth weight: _____ Lbs. _____ Oz.

Discharge weight: _____ Lbs. _____ Oz.

☐ Vaginal Delivery ☐ Caeasarian Section

Premature? ..... Y N _____ Weeks

Jaundice? ..... Y N

Multiple Birth? .....Y N _____

Pregnancy Number _____

Are immunziations up to date? ☐ Yes ☐ No

Coastal Ear, Nose and Throat

Patient: _____

Family History **Please circle if any blood relative has suffered any of the following:**

Alcoholism Anemia Anesthesia complications Arthritis Asthma Bleeding easily Blindnes
Cancer Crib death Diabetes Hay fever Hearing Loss Heart disease High cholesterol
Hypertension Migraines Renal (kidney) disease Stroke Thyroid disease

Please list siblings:

Name	Age	Sex	Health

Social History **Please circle appropriate response:**

Is there a history of exposure to second hand smoke? Y N **Is your child in day care?** Y N

Is there a history of exposure to excessive noise? Y N **Are there pets in the house?** Y N

Review of systems **Please circle Y or N if your child has had any of these symptoms.**

Constitution

Appetite Loss..... Y N
Bad breath/taste..... Y N
Chills..... Y N
Fatigue..... Y N
Fever..... Y N
Difficulty sleeping..... Y N
Daytime sleepiness..... Y N
Weight Y N

Other

Night Sweats..... Y N
Head banging..... Y N
Fussy/Irritable..... Y N
Speech/Language Difficulty..... Y N

Ear, Nose, Throat

Ear Y N
Ear drainage..... Y N
Ear infection..... Y N
Nose bleeds..... Y N
Sinus problems..... Y N
Sore Y N
Snoring..... Y N
Diffculty swallowing..... Y N
Decreased hearing..... Y N
Decreased smell..... Y N
Ear Pulling..... Y N

Neurology

Dizzness..... Y N
Headaches..... Y N

Respiratory

Cough, chronic..... Y N

Cardiovascular

Heart palpitations..... Y N

Gastroenterology

Abdominal pain..... Y N
Constipation..... Y N
Diarrhea..... Y N
Persistant Nausea..... Y N
Persistant vomiting..... Y N

Skin

Rash..... Y N

Genitourinary

Frequent urinary infections..... Y N