Peyton Manning Children's Hospital Ear, Nose, and Throat Center

8402 Harcourt Rd, Suite 732 Indianapolis, IN 46260 Ph (317) 338 – 6815

Patient Name: _____ Date of Birth: _____ Male Female

Primary Care Physician: _____
Other Physicians involved in care: _____
Reason for today's visit? _____
Have we treated any other members of your family? Y / N If so, who _____

Neonatal Medical History:

Born on time? Y / N if not how many weeks gestation? _____ Birth Weight: _____
Passed the Newborn Hearing Screen? Y / N
NICU after birth? Y / N If Yes how long? _____
Ventilator/breathing machine needed? Y / N If Yes how long? _____
Jaundiced? Y / N If Yes was treatment needed? _____
Pregnancy complicated? Y / N If Yes how so? _____

Medical History:

Any ALLERGIES to MEDICATION? Y / N If Yes which meds? _____
Immunizations up to date? Y / N
Food Allergies Y / N
Seasonal Allergies Y / N
Problems with Anesthesia? Y / N

Please list **medications** currently taking:

_____
_____
_____
_____
_____
_____
_____
_____
_____

Please list any **surgery** your child had and when:

_____
_____
_____
_____
_____
_____
_____
_____
_____

Please list any **chronic medical conditions** (like asthma, acid reflux, eczema, ADHD, etc.):

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Family History: (siblings, parents, grandparents)

Heart disease	Y / N
Diabetes	Y / N
Hearing loss at early age	Y / N
Anesthesia problems	Y / N

Social History:

Attend day care/school	Y / N
Use tobacco, alcohol, drugs	Y / N
Smokers	Y / N

Review of Systems:

Gen:	Fever	Y / N	Weight loss	Y / N
	Fatigue	Y / N	Night sweats	Y / N
Resp:	Chronic cough			Y / N
	Shortness of breath			Y / N
	Difficulty swallowing			Y / N
GU:	Bedwetting			Y / N
Skin:	Birthmarks			Y / N
Eyes:	Wears glasses			Y / N
ENT:	Wears hearing aids			Y / N
	Hearing loss			Y / N
	Ear pain	Y / N	Ringing in ears	Y / N
	Dizzy	Y / N	Nosebleeds	Y / N
	Hoarse	Y / N	Sinus infections	Y / N
	Chronic nasal Congestion			Y / N
	Chronic nasal drainage			Y / N
	Chronic sore throats			Y / N
	Mouth sores			Y / N
	Snoring			Y / N
CV:	Chest pain	Y / N	Heart murmur	Y / N
Neuro:	Seizures	Y / N	Stroke	Y / N
Endo:	Diabetes	Y / N	Thyroid disease	Y / N
Heme:	Bleeding problems			Y / N
Imm:	Immune problems			Y / N

_____ M.D. Reviewed _____
Signature Date Date

Previous Records Reviewed **Y / N**