Medical History Form v.11.10 – Children
The Ear Center of Greensboro, P.A., 1126 N. Church St., #201, Greensboro, NC 27401

Patient Name: _____ **Age:** _____ **Date:** _____
Sex: M or F **Weight:** _____
CC: For what problem is your child being evaluated? _____
Date started: _____
Total number of infections or episodes?_____
Last infection or episodes: _____
Symptoms: (Circle current symptoms)
Fussy, irritable, pain, poor sleeping, decreased appetite, others;_____
Signs: (Circle if applicable)
Fever, drainage, perforation in eardrum
Treatment: (Circle antibiotics prescribed)
Amoxicillin, Augmentin, Ceftin, Cefzil, Omnicef, Zithromax, Rocephin Injection,
Other medications:_____
Risk Factors:
Daycare: Yes or No Number of children in class? _____
Exposed to second hand smoke: Yes or No
Number of siblings: ____ Ages: _____ Siblings history of ear infections: Yes or No
Parent's history of ear disease: _____
Other Medical History: (Yes or No)
Previous tubes: _____ Tonsil/adenoids removed: _____
Cardiac problems: _____ Respiratory problems: _____
Other Surgeries or problems: _____
Birth History:
Full term: _____ Weeks of Gestation: _____
Vaginal or C-Section: _____ Complications: _____
Admittied to NICU? _____For how long?_____
Were they placed on a ventilator? _____ Oxygen? _____
Did they pass their newborn hearing screen? _____
Did they have yellow jaundice?_____Were they treated with lights?_____
Any genetic problems or syndromes? _____
Allergies:
What medications are they allergic to? _____
Any food allergies?_____Any seasonal allergies?_____
Other_____
Speech and Language:
Responding to sounds: Yes or No Babbling: Yes or No
Number of words: _____ Putting two words together: Yes or No
Speaking in sentences: Yes or No
Can you understand them clearly: Yes or No
Anesthesia History:
List any family history of anesthesia problems: _____
Fevers during anesthesia: Yes or No Prolonged wake-up time: Yes or No
Nausea or Vomiting: Yes or No Other problems with anesthesia: _____
American Indian Heritage? Yes or No
Bleeding Disorders: (circle if applicable)
Family history of: Hemophilia, Sickle Cell Anemia, Anemia, easy bruising,
easy bleeding, others: _____