Name____**D.O.B**______________________________

New Patient Questionnaire for minors (under age 18)

Were you sent to our office at the request of another physician? __________________________

What is the name of your primary care physician?_______________________________________

What are you here to see the doctor about today?_______________________________________

How long has the problem been present? ____

Are there any other associated problems? ____

Does anything make the problem better or worse?_______________________________________
(Location/quantity/severity/timing)

ENT Review	**NO**	**YES**		**NO**	**YES**
Pain swallowing	{ }	{ }	Past Medical History	{ }	{ }
Difficulty swallowing	{ }	{ }	Asthma	{ }	{ }
Difficulty breathing	{ }	{ }	Lung disease	{ }	{ }
Nasal bleeding	{ }	{ }	Thyroid disease	{ }	{ }
Nasal blockage	{ }	{ }	Heart disease	{ }	{ }
Snoring	{ }	{ }	High blood pressure	{ }	{ }
Coughing blood	{ }	{ }	Bleeding easily	{ }	{ }
Ear pain	{ }	{ }	Tuberculosis	{ }	{ }
Ear drainage	{ }	{ }	HIV or AIDS	{ }	{ }
Change in hearing	{ }	{ }	Sickle cell	{ }	{ }
Sore throat	{ }	{ }	Hepatitis	{ }	{ }
Sores in mouth	{ }	{ }	Diabetes	{ }	{ }
Hoarseness	{ }	{ }	Kidney disease	{ }	{ }
Change in voice	{ }	{ }	Anemia	{ }	{ }
Facial muscle weakness	{ }	{ }	GERD	{ }	{ }
Cancer	{ }	{ }			

List past major surgeries: {None} ____

List past hospitalizations: {None} ____

List all prescription medication: {None}
____
____

List any non-prescription medications or natural (herbal) products you may be taking: {None}
____
____

Allergies to medications: {None}

____

General review of symptoms: Do you presently have any problem in the following areas?
If Yes, explain.

	NO	YES	Explanation of problem
Constitutional (fever/ chills/ weight loss)	{ }	{ }	____________________________
Eyes (vision/ eye pain)	{ }	{ }	____________________________
Cardiac (heart/ blood vessels)	{ }	{ }	____________________________
Respiratory (lungs/ breathing)	{ }	{ }	____________________________
Gastrointestinal (stomach/ intestines)	{ }	{ }	____________________________
Genitourinary (genital/ kidney/ bladder)	{ }	{ }	____________________________
Musculoskeletal (muscles/ joints)	{ }	{ }	____________________________
Endocrine (hormones/ glands)	{ }	{ }	____________________________
Hematologic/Lymphatic (blood/ lymph glands)	{ }	{ }	____________________________
Integument (skin/ breast)	{ }	{ }	____________________________
Neurological (headaches/ nervous system)	{ }	{ }	____________________________
Allergy/ Immunol (seasonal allergies/ hay fever)	{ }	{ }	____________________________
Psychiatric	{ }	{ }	____________________________

Family History

Does any of your family have the following conditions?

	NO	YES
Bleeding tendency	{ }	{ }
Anesthesia reactions	{ }	{ }
Hearing loss	{ }	{ }
Cancer	{ }	{ }
Diabetes	{ }	{ }
Heart Disease	{ }	{ }

Social History	**NO**	**YES**
Was the child born prematurely? (before 37 weeks)	{ }	{ }
Were there any problems during the pregnancy or birth?	{ }	{ }
Was the child ever incubated or ventilated?	{ }	{ }
Any problems with development of speech and coordination?	{ }	{ }
Any learning issues?	{ }	{ }
Any noisy breathing?	{ }	{ }
Are any immunizations NOT up to date?	{ }	{ }
Any family history of alcohol, cigarette, or drug use?	{ }	{ }

Does the child live with: Mother Father Both Parents Other

If other, who has legal custody of the child? ____

To the best of my knowledge the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status.

_________________________________ _________________________________

Signature of patient or Guardian **Date**

_________________________________ _________________________________

Signature of Doctor **Date**