

Medical History Form

Established Patient

Patient's Name: _____ Date of Birth: _____

Primary Care Physician: _____

Your relationship to the patient: Parent Legal Guardian Other _____

Are your child's immunizations up to date? **Yes / No**

Since your child's last visit in our clinic have they been diagnosed with any new illnesses? **Yes / No**

If yes, please explain: _____

Since your child's last visit in our clinic have they had any surgeries? **Yes / No**

If yes, please explain: _____

Does your child have ANY medication allergies? **Yes / No**

If yes, which medication(s) and what type of reaction? _____

Since your child's last visit in our clinic have there been any medication changes? **Yes / No**

If yes, please explain: _____

Does your child currently have any of the following?

Ear, Nose, & Throat	Yes	No		Yes	No		Yes	No
Pulling at ears			Ear drainage			Ear pain		
Ear swelling			Itchy ear			Hearing loss		
Dizziness			Imbalance			Nasal obstruction		
Nasal congestion			Runny nose			Itchy nose		
Postnasal drip			Nose bleeds			Enlarged tonsils		
Snoring			Mouth breathing			Sore throat		
Bad breath			Throat clearing			Difficulty swallowing		
Hoarseness			Change in voice			Course cry		
Neck pain			Neck swelling			Thyroid mass		
Other Systems								
Wheezing			Cough			Breathing problems		
Stridor			Noisy breathing			Frequent spitting up		
Seizures			ADHD			ADD		
Easy bleeding			Easy bruising			Fatigue		

Name of individual completing form (print): _____

Signature: _____ Date: _____