ENT New Patient Questionnaire - Pediatric

☐ Male ☐ Other (specify: _____)
☐ Female

DATE: _____

NAME: _____

What is the reason for your child's visit? _____

Past Medical History

Has your child had or been treated for recurrent ear infections? ☐ Yes ☐ No
If yes, how many in the past 6 months? _____ past 12 months? _____

Has your child had or been treated for recurrent throat infections? ☐ Yes ☐ No
If yes, how many in the past 6 months? _____ past 12 months? _____

Do you have any hearing concerns? ☐ Yes ☐ No

Do you have any speech concerns? ☐ Yes ☐ No

Passed newborn hearing screening ☐ Yes ☐ No

Up to date on immunizations ☐ Yes ☐ No

Please list any previous hospitalizations or surgeries

Date	Reason/Procedure	Hospital

Birth History

Full Term (F) or Preterm (P)? **F / P** How many weeks? _____ Vaginal (V) or C-section (C)? **V / C**
If the delivery was by C-section, was the C-section planned or emergent? _____

Infections during pregnancy i.e. Grp B Strep ☐ Yes ☐ No
What infection (specify)?: _____
Neonatal jaundice ☐ Yes ☐ No
Meningitis ☐ Yes ☐ No
NICU stay/intubation ("breathing tube") ☐ Yes ☐ No

Family History

☐ Asthma
☐ Fibromyalgia
☐ Liver disease
☐ Diabetes
☐ Seizures
☐ Heart disease
☐ High blood pressure
☐ Osteoporosis
☐ Kidney disease
☐ Hearing loss/Deafness at birth
☐ Environmental allergies
☐ Stroke
☐ Depression
☐ Anxiety
☐ Other mental health conditions (specify: _____)
☐ Cancer (type(s): _____)
☐ Bleeding disorders (type: _____)
☐ Immune deficiency
☐ Gastritis/Ulcers/GERD
☐ Low/High Thyroid
☐ Thyroid cancer
☐ Autoimmune disease (Lupus, Rheumatoid arthritis, Crohn's dz, etc)
☐ Other: _____

Preferred Pharmacy: _____

Current Medications/Vitamins/Supplements

Name	Dose	Frequency

Medication or Other Allergies No known drug allergies, check here _____

☐ Environmental (specify: _____)

☐ Latex

☐ Medications Reaction

_____ _____

_____ _____

Social History

Does anyone in the house smoke **(Y/N)**? _____

List any pets in the home or write "none"? _____

Siblings **(Y/N)**? _____ (include number, ages)

Is your child in daycare **(Y/N)**? _____ School (what grade?) _____

If you are not the parent/legal guardian, what is your relationship to the child? _____

PLATTSBURGH ENT

ENT New Patient Questionnaire - Adult

DATE: _____

☐ Male ☐ Female
☐ Other (specify: _____)

NAME: _____ **Marital Status:** _____

What is the reason for your visit? _____

Past Medical History/Past Surgical History

- ☐ Asthma
- ☐ Fibromyalgia
- ☐ Liver disease
- ☐ Diabetes
- ☐ Seizures
- ☐ Heart disease
- ☐ High blood pressure
- ☐ Osteoporosis
- ☐ Kidney disease
- ☐ Hearing loss/Deafness at birth
- ☐ Environmental allergies
- ☐ Stroke
- ☐ Depression
- ☐ Anxiety
- ☐ Other mental health conditions (specify: _____)
- ☐ Cancer (type(s) _____)
- ☐ Bleeding disorder (type _____)
- ☐ Immune deficiency
- ☐ Gastritis/Ulcers/GERD
- ☐ Low/High Thyroid
- ☐ Autoimmune disease
- ☐ Hepatitis (type ___)
- ☐ Other: _____

Please list any previous hospitalizations or surgeries

Date	Reason/Procedure	Hospital

Family History

- ☐ Asthma
- ☐ Fibromyalgia
- ☐ Liver disease
- ☐ Diabetes
- ☐ Seizures
- ☐ Heart disease
- ☐ High blood pressure
- ☐ Osteoporosis
- ☐ Kidney disease
- ☐ Hearing loss/Deafness at birth
- ☐ Environmental allergies
- ☐ Stroke
- ☐ Depression
- ☐ Anxiety
- ☐ Other mental health conditions (specify: _____)
- ☐ Cancer (type(s): _____)
- ☐ Bleeding disorders (type(s): _____)
- ☐ Immune deficiency
- ☐ Gastritis/Ulcers/GERD
- ☐ Low/High Thyroid
- ☐ Autoimmune disease (Lupus, Rheumatoid arthritis, Crohn's dz, etc)
- ☐ Complications from anesthesia or sudden unexplained death

Social History

Do you presently smoke? **Y / N** (circle one). If so, how much? _____ # packs per day, _____ # of years
Have you ever smoked? **Y / N** (circle one). If so, how much? _____ # packs per day, _____ # of years.
What year did you quit? _____
Do you drink alcohol? **Y / N** (circle one). If yes, # drinks per day: _____
Have you ever used any other addictive substances? Name: _____

Preferred Pharmacy: _____

Current Medications/Vitamins/Supplements

Name	Dose	Frequency

Allergies No known drug allergies, check here _____

- ☐ Environmental (specify: _____)
- ☐ Latex
- ☐ Medications

Medications	Reaction

Review of Symptoms: Please mark (X) in the available blanks if any of the following apply to you **NOW** or in the **PAST**:

Now	Past	**Head, Eyes, Ears, Nose, Throat**
[ ]	[ ]	Noise exposure
[ ]	[ ]	Head injury or concussion
[ ]	[ ]	Draining or painful ears
[ ]	[ ]	Hearing loss
[ ]	[ ]	Ringing in the ears
[ ]	[ ]	Dizziness or loss of balance
[ ]	[ ]	Chronic facial pain or headaches
[ ]	[ ]	Chronic nasal congestion or drainage
[ ]	[ ]	Frequent nose bleeds
[ ]	[ ]	Difficulty swallowing
[ ]	[ ]	Hoarseness
[ ]	[ ]	Throat pain
[ ]	[ ]	Jaw pain
[ ]	[ ]	Chronic cough
[ ]	[ ]	Tooth pain/Loose teeth/Bite problems
[ ]	[ ]	Snoring/Sleep Apnea
[ ]	[ ]	Double vision/Eye pain/Change in vision
		General
[ ]	[ ]	Unexplained fever/Night sweats
[ ]	[ ]	Unexplained weight loss or pain
[ ]	[ ]	Joint pains and swelling
		Lungs
[ ]	[ ]	Coughing up blood
[ ]	[ ]	Persistent wheezing/Asthma
[ ]	[ ]	Shortness of breath
[ ]	[ ]	Abnormal chest x-ray
[ ]	[ ]	History of TB
		Heart - Circulation
[ ]	[ ]	Chest pain
[ ]	[ ]	Heart palpitations/Heart rhythm disturbance
[ ]	[ ]	Leg vein trouble/Leg pain when walking
[ ]	[ ]	Ankle swelling
		Psychiatric/Mental Health
[ ]	[ ]	Depression
[ ]	[ ]	Anxiety
[ ]	[ ]	Post-traumatic stress disorder (PTSD)

Now	Past	**Urinary**
[ ]	[ ]	Frequent urination/Trouble holding urine
[ ]	[ ]	Trouble starting urine
[ ]	[ ]	Urinate more than two times a night
[ ]	[ ]	Stress or urge incontinence
		Nervous System
[ ]	[ ]	Fainting spells (blackouts)
[ ]	[ ]	Convulsions (seizures, fits, epilepsy)
[ ]	[ ]	Tremor (shaking, trembling)
[ ]	[ ]	Paralysis (or weakness of any body part)
[ ]	[ ]	Numbness (body parts "go to sleep")
		Females
[ ]		Pregnant (Any possibiity?)
		Endocrine System
[ ]	[ ]	Dry skin
[ ]	[ ]	Hot/Cold intolerance
[ ]	[ ]	Thirst
[ ]	[ ]	Appetite change
[ ]	[ ]	Rapid weight gain/loss
[ ]	[ ]	Excessive fatigue
		Allergy/Immune System
[ ]	[ ]	Hives or chronic itching
[ ]	[ ]	Previous allergy workup
[ ]	[ ]	Hay fever
		Heme/Lymph System
[ ]	[ ]	Easy bruising
[ ]	[ ]	Bleeding problems
[ ]	[ ]	Taking blood thinners
[ ]	[ ]	Enlarged glands
		Stomach - Gastrointestinal
[ ]	[ ]	Heartburn/Regurgitation/Indigestion
[ ]	[ ]	Frequent or severe stomach pain
[ ]	[ ]	Frequent or severe vomiting
[ ]	[ ]	Vomiting blood