



MEDICAL HISTORY

Is this your family's first
visit to our office?

YES

NO

Today's Date: _____

Child's Name: _____ Preferred Name: _____

Date of Birth: _____ Age _____ Gender / Sex: Male Female

Child resides with: Both Parents Mother Father Other _____

Medical Decision Making Authority is with: Both Parents Mother Father Other _____

Mother's Name: _____ DOB: _____ Home #: _____

Mother's Address: _____ Work #: _____
(if different than patient's)

Father's Name: _____ DOB: _____ Home #: _____

Father's Address: _____ Work #: _____
(if different than patient's)

Legal Guardian's Name: _____ DOB: _____ Home #: _____

Guardian's Address: _____ Work #: _____
(if different than patient's)

Insured's Name: _____

Employer Name: _____ Phone #: _____

Employer Address: _____

Primary Care Physician: _____ Referring Physician (if different): _____

Who is with the child today? _____ Relationship to Patient: _____

Reason for today's visit: _____

What *specific question(s)* regarding your child's Ears, Nose, and Throat care would you like answered today? _____

Patient Information:

Office Use Only	Age: _____	Weight: _____	Height: _____	Pulse: _____	Resp: _____
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	Yes	No	Explain
Has s/he seen a doctor for today's problem?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Is this a "second opinion" appointment?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Is s/he presently in good health?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Is s/he being treated for other illnesses?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Past serious illness / hospitalization?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Has s/he ever had a blood transfusion?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Any reaction to anesthesia?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Is Sickle Cell Disease / Trait status known?	<input type="checkbox"/>	<input type="checkbox"/>	_____

Date of last physical examination: _____

Allergies to Medications? Yes No

If yes, please list and describe reactions: _____

Medications s/he is presently taking? _____

Surgeries in the past, list all, including date(s): _____

Family History of Bleeding or Clotting Disorder? Yes No

If yes, please explain _____

Vaccinations up-to-date? Yes No **Reactions to vaccinations?** Yes No

If yes for vaccination reactions, please explain: _____

Tobacco smokers in the household? Yes No If yes, who? _____

Mother's Pregnancy and Child's Birth History:

Length of Pregnancy: _____ Birth Weight: _____

Birth medications delivered to mother: _____ to child: _____

Did any of the following occur during pregnancy *or* soon after delivery?

	Yes	No		Yes	No
Prolonged Labor	<input type="checkbox"/>	<input type="checkbox"/>	Caesarian Section	<input type="checkbox"/>	<input type="checkbox"/>
Medications	<input type="checkbox"/>	<input type="checkbox"/>	Feeding Problems	<input type="checkbox"/>	<input type="checkbox"/>
Rh incompatibility	<input type="checkbox"/>	<input type="checkbox"/>	Jaundice	<input type="checkbox"/>	<input type="checkbox"/>
Measles	<input type="checkbox"/>	<input type="checkbox"/>	Low Apgar Scores	<input type="checkbox"/>	<input type="checkbox"/>
Illnesses/Infections	<input type="checkbox"/>	<input type="checkbox"/>	Neonatal Intensive Care Unit	<input type="checkbox"/>	<input type="checkbox"/>
Substance Abuse	<input type="checkbox"/>	<input type="checkbox"/>	Oxygen (mother or child)	<input type="checkbox"/>	<input type="checkbox"/>
Heart Problems	<input type="checkbox"/>	<input type="checkbox"/>	Intubation Tube (airway)	<input type="checkbox"/>	<input type="checkbox"/>

Patient's Name _____

Daniel L. Wohl, M.D., P.A.

Reviewed by: _____

Patient Past Medical History:

	Yes	No		Yes	No
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Persistent Hoarseness	<input type="checkbox"/>	<input type="checkbox"/>
Eye Disease	<input type="checkbox"/>	<input type="checkbox"/>	Esophageal Reflux Symptoms	<input type="checkbox"/>	<input type="checkbox"/>
Intestinal Problems	<input type="checkbox"/>	<input type="checkbox"/>	Kidney / Urinary tract	<input type="checkbox"/>	<input type="checkbox"/>
Allergy / Immunology	<input type="checkbox"/>	<input type="checkbox"/>	Serious Injuries	<input type="checkbox"/>	<input type="checkbox"/>
Muscle / Skeletal Disease	<input type="checkbox"/>	<input type="checkbox"/>	Learning / Developmental Delay	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding Disorders	<input type="checkbox"/>	<input type="checkbox"/>	Emotional problems	<input type="checkbox"/>	<input type="checkbox"/>
Lung problems / Asthma	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
Heart problems / Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Bad scarring	<input type="checkbox"/>	<input type="checkbox"/>
Hearing problems	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid / Diabetes / Endocrine	<input type="checkbox"/>	<input type="checkbox"/>
Frequent Infections	<input type="checkbox"/>	<input type="checkbox"/>	Circulatory problems	<input type="checkbox"/>	<input type="checkbox"/>
Snoring / Mouth Breathing	<input type="checkbox"/>	<input type="checkbox"/>	Communicable Disease	<input type="checkbox"/>	<input type="checkbox"/>
Sleep Difficulties	<input type="checkbox"/>	<input type="checkbox"/>	Illicit / Recreational Drugs	<input type="checkbox"/>	<input type="checkbox"/>
Swallowing Difficulties	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric problems	<input type="checkbox"/>	<input type="checkbox"/>
Voice Changes	<input type="checkbox"/>	<input type="checkbox"/>	Reproductive Disorders	<input type="checkbox"/>	<input type="checkbox"/>
Neurology / Seizures	<input type="checkbox"/>	<input type="checkbox"/>			

Family History of:

Ear, Nose or Throat Problems Yes No

If yes, please explain _____

Cancer Diabetes Heart Disease Anesthesia Problems Asthma

(If Applicable) Is there a chance that she is pregnant? Yes No

(If Applicable) Does / Has the patient use/d tobacco? Yes No

(If Applicable) Does the patient drink alcoholic beverages,
or have they consumed alcoholic
beverages, in the past? Yes No

If yes, please explain _____

Other Past Medical History Comments: _____

Audiology & Hearing History

Do you think your child hears normally? Yes No

If no, please explain: _____

Did your child pass the newborn hearing screening? Yes No

Has your child's hearing been tested before? Yes No

If yes, when? _____ Results: _____

Ear infections as a child? Yes No

If yes, first ear infection occurred at what age? _____

Ventilation tubes inserted? Yes No

If yes, when and by whom? _____

Has your child had:

	Yes	No	Explain
Drainage from the ear	<input type="checkbox"/>	<input type="checkbox"/>	_____
Dizziness or Balance Problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Fevers	<input type="checkbox"/>	<input type="checkbox"/>	_____
Head Injury	<input type="checkbox"/>	<input type="checkbox"/>	_____
Measles/Mumps	<input type="checkbox"/>	<input type="checkbox"/>	_____
Food Allergies	<input type="checkbox"/>	<input type="checkbox"/>	_____
Environmental Allergies	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chronic Colds	<input type="checkbox"/>	<input type="checkbox"/>	_____
Noise Exposure	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ringing in the ears	<input type="checkbox"/>	<input type="checkbox"/>	_____

Do any family members have hearing loss? _____

Do you feel your child's speech acquisition and language development are progressing normally?

Yes No If no, please explain _____

Has your child ever been prescribed hearing aids? Yes No

If yes, please give date of initial fitting: _____



Do you have any *other* Ears, Nose, and Throat concerns regarding your child? _____

Thank you! 😊

Recent "ENT" History

	Yes	No		Yes	No
EARS:					
Recurrent infections?	<input type="checkbox"/>	<input type="checkbox"/>	Persistent Middle Ear "fluid"?	<input type="checkbox"/>	<input type="checkbox"/>
Outer Ear Drainage?	<input type="checkbox"/>	<input type="checkbox"/>	Suspected Hearing Loss?	<input type="checkbox"/>	<input type="checkbox"/>

How often treated? What medications? _____

NOSE:					
Recurrent "colds"?	<input type="checkbox"/>	<input type="checkbox"/>	Recurrent "sinusitis"?	<input type="checkbox"/>	<input type="checkbox"/>
Persistent congestion?	<input type="checkbox"/>	<input type="checkbox"/>	Persistent cough?	<input type="checkbox"/>	<input type="checkbox"/>

How often treated? What medications? _____

THROAT:					
Recurrent sore throats?	<input type="checkbox"/>	<input type="checkbox"/>	Recurrent tonsillitis?	<input type="checkbox"/>	<input type="checkbox"/>
Normal swallowing?	<input type="checkbox"/>	<input type="checkbox"/>			

How often treated? What medications? _____

HEAD & NECK:

How often treated? What medications? _____

VOICE:

How often treated? What medications? _____
