Oregon Health & Science University
Hospitals and Clinics
Pediatric Otolaryngology

NEW PATIENT QUESTIONNAIRE

ACCOUNT NO.
MED. REC. NO.
NAME
BIRTHDATE

Patient Identification

Who is your child's pediatrician? _____

Who referred your child to see us? _____

HISTORY OF PRESENT ILLNESS:

Reason for visit: _____

When did the problem(s) start? _____

Does anything make it better or worse? _____

Any other associated symptoms? _____

Please list your child's allergies, including any allergies to medication: _____

_____

What medication is your child taking now? (regularly and only as needed). Please include **ALL** prescriptions, over the counter medications, vitamins, herbs, and complementary or alternative medications: _____

_____

_____

List any surgeries and the approximate dates: _____

_____

List any hospitalizations (not including trips to the Emergency Room): _____

_____

Are your child's immunizations current? ☐ Yes ☐ No

BIRTH HISTORY:

Was your child born on time, early, or late? _____ Birth Weight: _____

Problems during the pregnancy: _____

Did your child have any problems since birth (heart murmur, hearing loss, etc.)? _____

SOCIAL HISTORY:

How many siblings does your child have? _____ What grade is your child in? _____

Is your child in daycare? _____ If yes, how many children are in the daycare? _____

Is your child exposed to any type of smoke? _____ Do you smoke? ☐ Yes ☐ No

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REVIEW OF SYSTEMS:

Does your child have a problem with any of the following, either now or in the past? (*If yes, please explain):*

Fevers or Weight Loss _____

Eyes or Vision _____

Skin _____

Heart, Blood Vessels, Lungs _____

Urinary Tract (bladder), Kidneys _____

Digestive Tract _____

Muscles or Bones _____

Nerves or Behavior _____

Immune System _____

Anemia, Bleeding, Clotting _____

FAMILY HISTORY:

Does anyone on either side of the family (excluding the patient) have any of the following conditions? If yes, who in the family has the problem?

Chronic Ear Infections	Yes / No	_____
Hearing Loss (especially before the age of 20)	Yes / No	_____
Blindness (especially before the age of 20)	Yes / No	_____
Cleft Lip and / or Cleft Palate	Yes / No	_____
Allergies (“hay fever”)	Yes / No	_____
Asthma	Yes / No	_____
Bleeding Problems	Yes / No	_____
Problems with Anesthesia	Yes / No	_____
Any other medical conditions that run in the family	Yes / No	_____

Completed by:_____ Date_____

If completed by someone other than the patient, what is your relationship to the patient?_____

FOR OFFICE USE ONLY

Reviewed by_____ Date:_____

Comments: _____

**** Please keep this questionnaire with you until you see the doctor ****