NeoHealth
NORTHEASTERN OKLAHOMA COMMUNITY HEALTH CENTERS, INC

Tahlequah Ear Nose and Throat Clinic
Pediatric Medical History

PATIENT NAME: _____ DOB: _____ TODAY'S DATE: _____

REASON FOR TODAY'S VISIT_____

PREVIOUS TREATMENT FOR THIS CONDITION_____

WHO IS BRINGING CHILD IN TODAY? _____ RELATIONSHIP TO CHILD? _____

PCP:_____ PHARMACY:_____

ALL SURGERIES	DATE OF SURGERY	DRUG ALLERGIES	☐ NO KNOWN DRUG ALLERGIES

ALL MEDICAL PROBLEMS	CURRENT MEDICATIONS AND DOSES (INCLUDING OVER THE COUNTER)

FULL TERM BIRTH ☐Yes ☐No Premature # of weeks ____
NEWBORN HEARING SCREEN ☐Passed ☐Failed
ATTENDS ☐Daycare ☐School ☐Home schooled

Pregnancy/birth complications _____
VACCINATION up to date ☐Yes ☐ No
EXPOSURE TO SECOND HAND SMOKE ☐Yes ☐No

FAMILY MEDICAL HISTORY
Mother: ☐Alive Died age _____ Significant Medical Problems _____
Father: ☐Alive Died age _____ Significant Medical Problems _____
Siblings: ____# sisters & _____# brothers Significant Medical Problems_____
Personal or family history of anesthesia problems? ☐No ☐Yes Personal or family history of bleeding disorder? ☐No ☐Yes

Please complete the section that is age appropriate for your child.

Infants 0-12 months and Toddlers 1-3 years

(Y) (N)	(Y) (N)	(Y) (N)
____ ____Recent Fevers	____ ____Heart Murmur	____ ____Colic/Reflux
____ ____Change in Activity	____ ____Cardiac Problem	____ ____Vomiting
____ ____Weight Changes	____ ____Asthma	____ ____Diarrhea
____ ____Nasal Congestion	____ ____Snoring	____ ____Decreased Appetite
____ ____Runny Nose	____ ____Cough	____ ____Frequent UTIs
____ ____Mouth Breathing	____ ____Cyanosis (blue skin)	____ ____Yeast Infection
____ ____Oral Thrush (yeast)	____ ____Seizure Activity	____ ____Growth Disturbance
____ ____Hearing Concerns	____ ____Development Delay	____ ____Rashes
____ ____Speech Concerns	____ ____Easy Bruising	____ ____ Discoloration around eyes
____ ____Unusual Head Shape	____ ____Easy Bleeding	____ ____Eye discharge/Puffy eyes
	____ ____Blue skin with crying	

Pre-School 4-6 years, School Aged 7-13 years and Adolescent 14-17 years:

(Y) (N)	(Y) (N)	(Y) (N)
____ ____Recent Fevers	____ ____Snoring	____ ____Growth Disturbance
____ ____Change in Activity	____ ____Cough	____ ____Excessive Fatigue
____ ____Weight Difficulties	____ ____Witnessed Apnea	____ ____Limb Deformity
____ ____Nasal Congestion	____ ____Seizure Activity	____ ____Scoliosis
____ ____Sore Throat	____ ____Development Delay	____ ____Joint/Muscle Aches
____ ____Runny Nose	____ ____Easy Bruising	____ ____Rashes
____ ____Mouth Breathing	____ ____Easy Bleeding	____ ____Eczema
____ ____Hearing Concerns	____ ____Allergies Suspected	____ ____Eye discharge/Puffy eyes
____ ____Speech Concerns	____ ____Reflux	____ ____Discoloration around eyes
____ ____Headaches	____ ____Vomiting	____ ____Bed Wetting
____ ____Heart Murmur	____ ____Diarrhea	____ ____ADD/ADHD
____ ____Cardiac Problem	____ ____Asthma/RAD	____ ____Wheezing