OMNI Healthcare

Putting *Care* Back In Healthcare

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Pediatric Otolaryngology-Head & Neck Surgery

New Patient History Form

****** Please complete ALL the information; if Not Applicable, please write "N/A" ******

Date of your first visit with Dr. Malis: _____

Person Completing Form and Relationship: _____

Patient's Name: _____

Date of Birth: _____

Referring Physician: _____

Reason for today's visit: _____

Medication **ALLERGIES**: _____

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

Birth History

Birth Weight: _____

Fullterm: O Yes O No If early, born at how many weeks? _____

Any problems with pregnancy / delivery? O Yes O No

If yes, what: _____

NICU Stay? O Yes O No

If yes, how long? _____

Was your child on the ventilator? O Yes O No

If yes, how long? _____

Breastfeed? O Yes O No If yes, how long? _____

Does your child take a bottle, "sippy" cup, or pacifier to bed? O Yes O No

Current Medications (Please list ALL)

_____ _____ _____

_____ _____ _____

Previous Hospitalizations /Surgeries (Month/Year)

_____ _____ _____

_____ _____ _____

Does your child or anyone in the family have problems with Anesthesia? O Yes O No

- If yes, who and what was the problem? _____

Medical History

- Please mark the circle if your child has / had any of the following medical problems?

O Heart

- Healthy / No Problems / Not Applicable
- Congenital Heart Disease
- Murmur
- Needs antibiotics for dental procedures
- Other; specify: _____

O Lungs / Breathing

- Healthy / No Problems / Not Applicable
- Asthma
- Recurrent Croup
- Cystic Fibrosis
- Bronchopulmonary Dysplasia
- Laryngomalacia or Tracheomalacia
- Other; specify: _____

O Stomach / Bowel / Digestive

- Healthy / No Problems / Not Applicable
- Reflux
- G-Tube
- Other; specify: _____

O Neurological

- Healthy / No Problems / Not Applicable
- Seizures
- Cerebral Palsy
- Hypotonia

- Neurological Continued
  - ADD / ADHD
  - Developmental Delay
  - Other; specify: _____
- Skin
  - Healthy / No Problems / Not Applicable
  - Eczema
  - Birthmarks (e.g. Hemangiomas, Café Au Lait spots, etc)
  - Other; specify: _____
- Eyes
  - Healthy / No Problems / Not Applicable
  - Strabismus
  - Glasses / Contacts
  - Other; specify: _____
- Endocrine
  - Healthy / No Problems / Not Applicable
  - Thyroid Disease
  - Diabetes
  - Obesity
  - Other; specify: _____
- Blood
  - Healthy / No Problems / Not Applicable
  - Bleeding Disorder
  - Sickle Cell Disease / Trait
  - Other; specify: _____
- Kidney
  - Healthy / No Problems / Not Applicable
  - Recurrent Urinary Tract infections
  - Other; specify: _____

- O Allergy / Immunology
  - Healthy / No Problems / Not Applicable
  - Immune Deficiency
  - Seasonal Allergies / “Hayfever”
  - Other; specify: _____
- O Other medical problems not listed above; please specify:

_____

Family History

Please mark the circle if a family member has / had any of the following medical problems:

- O Healthy / No Problems / None Applicable
- O Bleeding problems
- O Sickle Cell Disease
- O Seasonal Allergies
- O Ear, Nose, or Throat problems
- O Other; specify: _____

Social History

Is your child in daycare? O Yes O No

If yes, started when? _____

Hours per day _____

Days per week _____

Average number of children in the daycare _____

Is your child in school? O Yes O No

Grade _____ Name of school _____

Does any family member smoke? O Yes O No

Who? _____

Do they smoke in the house? O Yes O No

In the car? O Yes O No

Child lives with: _____

Legal Guardian Name(s): _____

Reviewed by Dr. Malis: _____