



David J. Malis, MD, FACS, FAAP
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: _____

Who Is Your Child's Pediatrician: _____

Has Dr. Malis seen any relatives/friends? Yes No

If "Yes", who: _____

Reason for today's visit: _____

Medication **ALLERGIES**: _____

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

Birth History

Birth Weight: _____

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

Any problems with pregnancy / delivery? Yes No

 If yes, what: _____

NICU Stay? Yes No

 If yes, how long? _____

Was your child on the ventilator? Yes No

 If yes, how long? _____

Breastfeed? Yes No If yes, how long? _____

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

Current Medications (Please list ALL)

Previous Hospitalizations /Surgeries (Month/Year)

Does your child or anyone in the family have problems with Anesthesia? Yes 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?

Heart

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

Lungs / Breathing

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

Stomach / Bowel / Digestive

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

Neurological

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

O Neurological Continued

- Developmental Delay
- Autism
- Other; specify: _____

O Skin

- Healthy / No Problems / Not Applicable
- Eczema
- Birthmarks (e.g. Hemangiomas, Café Au Lait spots, etc)
- Other; specify: _____

O Eyes

- Healthy / No Problems / Not Applicable
- Strabismus
- Glasses / Contacts
- Other; specify: _____

O Endocrine

- Healthy / No Problems / Not Applicable
- Thyroid Disease
- Diabetes
- Obesity
- Other; specify: _____

O Blood

- Healthy / No Problems / Not Applicable
- Bleeding Disorder
- Sickle Cell Disease / Trait
- Other; specify: _____

O 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: _____

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:

Healthy / No Problems / None Applicable

Bleeding problems

Sickle Cell Disease

Seasonal Allergies

Ear, Nose, or Throat problems

Other; specify: _____

Social History

Is your child in daycare? Yes No



If yes, started when? _____

Hours per day _____

Days per week _____

Average number of children in the daycare _____

Is your child in school? Yes No



Grade _____ Name of school _____

Does any family member smoke? Yes No



Who? _____

Do they smoke in the house? Yes No

In the car? Yes No

Child lives with: _____

Legal Guardian Name(s): _____