

Please answer this questionnaire to the best of your knowledge. The information is confidential and will be used by the physicians of Southdale Otolaryngology to evaluate and treat your child's medical problems.

**SOUTH DALE OTOLARYNGOLOGY P.A.
Pediatric Medical History Form**

Today's Date _____

PATIENT NAME _____ Date of BIRTH _____

Preferred pharmacy and location: _____

Your Child's Pediatrician or Family Doctor: _____

Is your child in good health? Yes/No _____

Does your child have any current or past medical problems? Yes/No (i.e. heart, lung, urinary tract, blood disorders, immune disorders, etc.) _____

Was there a problem with your child's pregnancy, labor and delivery? Yes/No _____

Previous Surgery or Hospitalizations? _____

PRESENT Medications: _____

ALLERGIES: Medications?
Hay Fever, dust, etc.?

Does your child have problems with excessive bleeding or easy bruising? Yes/No

Family history of unusual or severe diseases or bleeding problems? Yes/No _____

Is your child in day care? Yes/No If yes, patient is in daycare with: More than 10 children / Less than 10 children

Are there any smokers in the home? Yes/No _____

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

Any other information you would like to share about your child? _____

Please list siblings: (names, ages, medical problems):

Physician use only: Date /Drs Initials

