UT Physicians

UTHealth | McGovern Medical School
The University of Texas Health Science Center at Houston

Pediatric ENT New Patient Questionnaire

Name	MRN	DOB	Date

Telephone
H W M

Pharmacy
Name Telephone

How did you hear about us?
□ Sent by another physician (If so, please give name below.)
□ Sent by a friend
□ Internet search
□ UT reputation
□ Other *(Specify)*

Physician #1 (☐ sent by this physician)
Name Fax Telephone

Address City, State Zip

Physician #2 (☐ sent by this physician)
Name Fax Telephone

Address City, State Zip

Important Note on Medical Records and Previous Imaging

Please be sure to bring your previous medical records. In particular, previous CT scans and MRI scans of the nose and sinuses are very important. Please try to obtain the actual films (not just the radiology reports); images on CD-ROM are preferable.

What symptom gives your child the most trouble?

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History of Present Illness

What is the reason for your child's visit today?

How long has your child had this problem?

What other physician has treated your child for this problem?

Has your child been evaluated by any of the following:
O Allergist
O Pulmonologist
O Speech Pathologist
O Orthodontist/Dentist
O Gastroenterologist

Past Medical History

Does your child now have or has he/she ever had any of the following?
O ADHD
O AIDS/HIV positive
O Allergies
O Anemia
O Asthma
O Blood disease
O Blood transfusion
O Cancer
O Congenital heart disease
O Cystic Fibrosis
O Diabetes
O Down Syndrome
O Ear infections
O Epilepsy / seizures
O Hearing Problems
O Heart Failure
O Hemophilia
O Hepatitis A
O Hepatitis B or C
O Hospitalized at birth
O Irregular heartbeat
O Kidney problems
O Lung disease
O Psychiatric disease
O Reflux disease
O Sickle cell disease
O Sinus infections
O Strep throat
O Tuberculosis

What is your child's birth history?
O Full-term
O Pre-term (_____# weeks)
O Single
O Twins (O Fraternal O Identical____)
O Multiple (#____)

Please list your child's previous surgical procedures.

Please list your child's previous hospitalizations.

Does your child have any other medical problems not listed above?
O Yes
O No
(If yes, please give details.)

Please list your child's current medications.

Is your child allergic to any medications?
O Yes
O No
(If yes, please give details.)

Is your child allergic to latex?
O Yes
O No
(If yes, please give details.)

Does your child have any other allergies?
O Yes
O No
(If yes, please give details.)

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Family Medical History

Do any of your family members (living or dead) have any history of the following:

- O AIDS
- O Allergies
- O Anesthesia problems
- O Asthma
- O Blood disease
- O Cancer
- O Cystic Fibrosis
- O Diabetes
- O Dizziness
- O Ear fluid or infections
- O Excessive bleeding
- O Epilepsy / seizures
- O Headaches
- O Hearing loss
- O Hemophilia
- O High blood pressure
- O Kidney problems
- O Sickle cell disease
- O Sinus disease
- O Sleep apnea
- O Stroke
- O Thyroid disease
- O Tonsil problems
- O Tuberculosis

Social History

Is your child in daycare?
O Yes
O No

Is your child in school? Details
O Yes
O No

Does your child use a pacifier? Details
O Yes
O No

Does anyone in your household smoke? Details
O Yes
O No

Please list siblings.

Please list siblings previously seen in the Department and the reason(s) for the visit or treatment.