CHOC Children's Specialists

Gurpreet S. Ahuja, MD, FAAP
Nguyen S. Pham, MD
Kevin C. Huoh, MD
Division of Pediatric Otolaryngology
1010 W. La Veta Ave., #640 Orange, CA 92868
Phone (714) 633-4020 Fax (714) 953-5462

HEALTH HISTORY RECORD *Please answer each question (to be completed by parent or guardian)*

Patient's Name:_____Age:_____Sex:_____
Referring Doctor:_____Name of Pediatrician:_____
Other Doctors providing care for your child: _____
What is the reason for today's visit? _____
_____

Medical History: Child's birth weight:_____Was your child a premature baby?____How many weeks?_____
Any problems during the pregnancy? What kind?:_____
Any chronic conditions or illnesses? _____
Has your child had any surgeries?_____Please list type and approximate dates:_____
_____
Has your child ever been hospitalized for any other reasons?_____Please explain:
_____
Are immunizations up to date?__If no, please explain:_____
What grade is your child in (if not in school, are they in daycare or preschool)? _____
Please list members of the household: _____
What is your child's current height/length?_____ What is your child's current weight?_____

Family Medical History: ***Please check yes or no if any relatives have or had any of the following illnesses:***

	Yes	No	Family member(s) relation to patient
Ear or Hearing problem	☐	☐	_____
Cancer	☐	☐	_____
Bleeding disorder	☐	☐	_____
Problems with anesthesia	☐	☐	_____
Heart problem	☐	☐	_____

Any other illness not listed above?_____
_____

Medication History:
Does your child have any allergies to medication? _____
Any other type of allergies (i.e. food, latex, cats, etc.)? _____
Please list any prescription and non-prescription medications your child is currently taking:
_____

System review: ***Does your child have or <u>EVER HAD</u> any of the following (check all that apply):***

- ❑ Recurrent ear infections
- ❑ Hearing loss
- ❑ Dizziness/Imbalance
- ❑ Speech problems
- ❑ Runny nose
- ❑ Sneezing
- ❑ Stuffy nose
- ❑ Itchy/watery eyes
- ❑ Recurrent Sinusitis
- ❑ Nose bleeds
- ❑ Bad breath
- ❑ Loud Snoring
- ❑ Recurrent sore throat/Tonsillitis
- ❑ Bedwetting
- ❑ Mouth breathing
- ❑ Swollen lymph nodes/glands
- ❑ Swallowing problems
- ❑ Headache/Sinus pain
- ❑ Asthma/Lung problems
- ❑ Cystic Fibrosis
- ❑ Recurrent pneumonia
- ❑ Stomach acid reflux
- ❑ Spitting up/vomiting
- ❑ Intestinal problems
- ❑ Immune Deficiency
- ❑ Unknown cause/recurrent fever
- ❑ Muscle weakness
- ❑ Failure to thrive
- ❑ Kidney Liver problems
- ❑ Bleeding disorder
- ❑ Vision/Eye problems
- ❑ Behavior/ problems
- ❑ Seizures
- ❑ Blood transfusion
- ❑ Anemia
- ❑ Skin condition/rashes
- ❑ Broken bones
- ❑ Other:_____.
- ❑ **All others negative**

I confirm that the above is true and correct to the best of my knowledge (Parents/Guardians please sign below)

Print Name: _____Signature:_____Date:_____

Office use only: Reviewed by:_____Date:_____