HEIDI HERAS, MD

ears, nose & throat specialist

PEDIATRICS HEALTH HISTORY

EARS • NOSE • THROAT • WWW.DRHEIDIHERAS.COM

Patient Name: ______________________ DOB ____________ ❑ Male ❑ Female

Parent/Guardian ______________________

Full Name of Referring Doctor ______________________ ❑ Dr ❑ NP ❑ PA

Reason for visit and symptoms ______________________

Race or Ethnicity: ❑ African American ❑ Asian/Pacific Islander ❑ White ❑ American Indian ❑ Hispanic ❑ Other Race or Ethnicity

Preferred language: ❑ English ❑ Spanish

Past Medical History/Major Illnesses or Injury

* Please check, if yes, and explain

❑ Was the child premature?

❑ Birth defects or Developmental Delay?

If yes, list ______________________

❑ Heart conditions ______________________

If yes, do they need antibiotic prophylaxis? Yes / No

❑ Bleeding problems Blood/Lymphatic ______________________

❑ Has the child had a bad reaction to anesthesia? ______________________

❑ Reaction to anesthesia in relative? ______________________

❑ Tonsillitis: # of times in 12 months ______________________

Previous year: ______________________

❑ Ear infections: # of times in 12 months ______________________

Previous year: ______________________

❑ Lung Problems/Asthma ______________________

❑ Sleep Apnea ______________________

❑ Neurological Problems ______________________

❑ Genitourinary ______________________

❑ Musculoskeletal ______________________

❑ Skin Problems ______________________

❑ Intestinal Problems/Liver ______________________

❑ Depression of other psychiatric illnesses ______________________

❑ Seizures ______________________

❑ Eye Problems ______________________

❑ Endocrine ______________________

❑ Immunologic problems ______________________

❑ Other: ______________________

Medication (Please list all medications you are currently taking, including vitamins, herbs, and over the counter medications): ______________________

Allergies: (Please list all the medications the child is allergic to and the reaction): ______________________

Has child been tested for environmental allergies? ❑ Yes ❑ No

Allergy to tape, foods, latex? If yes, please list:

Environmental allergies? ❑ Yes ❑ No

Is your child current on immunizations? ❑ Yes ❑ No

Did your child past their hearing test at birth? ❑ Yes ❑ No

If not, please explain: ______________________

Previous Hospitalizations — Date

Previous Surgeries — Date

Social History

Parents:

❑ Married ❑ Separated ❑ Divorced ❑ Not Married

Is the child adopted? . . . . ❑ Yes ❑ No

Child lives with: ❑ Both Parents ❑ Mom ❑ Dad ❑ Guardian

Smoking in the household? . . . . ❑ Yes ❑ No

Does the child attend day care? . . . . . . ❑ Yes ❑ No

Does the child attend school? . . . . ❑ Yes ❑ No

How many children in the household? ______________________

Please list any significant illnesses and cause of death of family members (Including heart, liver cancer and kidney):

____

Patient/Guardian Signature — **Date**

For office use only:

__/__/__ __/__/__ __/__/__

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