PEDIATRIC - New Patient Health History Form
(patient under age 13)

Last Name ________________________ First Name _________________________ M.I. ________

Date of Birth: ___/___/_____ Sex: M F

Home Phone: (____)_______________ Alt Phone: (____)_______________

If you would like us to send your ongoing medical records to another physician, please list them:

Family Doctor: ____________________ Referring Doctor: _________________________ Other Doctor: ___________________

Have you been seen by any of the physicians at Capital Otolaryngology? Yes No

Has a member of your family been seen by any of the physicians at Capital Otolaryngology? Yes (specify) _________ No

How did you hear about us? (please circle): Doctor Referral Internet Yellow Pages Insurance Friend Other ___________

Reason for today's visit: ____

____

Have you had any tests, scans (CT or MRI), or treatments for this problem: Yes No

If yes, what was done and which doctor ordered them: ____________________________________

Answer all questions

All responses are confidential

1. **MEDICAL HISTORY**
   Height_________ Weight _________

2. **PLEASE LIST ANY HEALTH CONDITIONS/ILLNESSES:**
   ____
   ____
   ____
   ____

3. **SURGICAL HISTORY**
   Please list any surgeries/hospitalizations you have had (please include date)? _____________________________
   ____
   ____

4. **MEDICATIONS**
   Please list all medications you take (include prescription & over-the-counter medications):

Med	**Dosage**	**Frequency**
___________________	______	________
___________________	______	________
___________________	______	________
___________________	______	________
___________________	______	________

5. **ALLERGIES (write 'none' if you have no known allergies)**
   a. Please list any **drug allergies**________________
   ____
   b. Please list any seasonal allergies or food allergies:_________________________________
   ____

6. **FAMILY HEALTH HISTORY**
   a. Please list any pertinent family medical conditions (and relation to patient)
   ____
   ____
   ____
   b. Does anyone in the household where the child resides smoke? YES NO

7. **PHARMACY: (Name, Location, Phone #)**
   ____
   ____

X ____

Patient/Guardian Signature **Print name**

____

Date