Dr. J. Patrick O'Neal

Otolaryngology (ENT)

Pediatric Patient History and Intake Form

Patient/Child Name _____ Date of Birth _____

Parent #1 _____ Parent #2 _____

Parents are: ○ Married ○ Single ○ Divorced ○ Separated Number of children at home _____

Primary language spoken at home _____

Patient's primary pediatrician or doctor _____

Birth History: ○ On Time ○ Early (if so, how many weeks?)_____ Birth Weight_____

Any problems with pregnancy or delivery? ○ No ○ Yes. What?_____

Number of days child spent in the hospital after birth: _____

Please check Yes or No for each symptom:

	Yes	No		Yes	No		Yes	No
Weakness/Tired	___	___	Racing Heart	___	___	Pain with Urination	___	___
Seizures	___	___	Stomach Pain	___	___	Blood in Urine	___	___
Ear Pain	___	___	Vomiting	___	___	Trouble Sleeping	___	___
Headaches	___	___	Blood in Stool	___	___	Sleeps too much	___	___
Throat Pain	___	___	Weight Loss	___	___	Trouble Swallowing	___	___
Neck Pain	___	___	Overeating	___	___	Neck Swelling	___	___
Runny Nose	___	___	Painful Periods	___	___	Eye Drainage	___	___
Eye Redness	___	___	Joint Pain	___	___	Trouble Hearing	___	___
Trouble Seeing	___	___	Jaundice	___	___	Hoarse Voice	___	___
Trouble Breathing	___	___	Fever/Chills	___	___	Heart Murmur	___	___
Cough	___	___	Snoring	___	___	Problems gaining weight	___	___
Wheezing	___	___	Chest Pain	___	___	Poor Eating	___	___
Constipation	___	___	Diarrhea	___	___	Spitting Up	___	___
Increased Urination	___	___	Irregular Period	___	___	Vaginal Discharge	___	___
Easy Bruising	___	___				Skin Problems/Rash	___	___

General Health History:

Has your child ever been hospitalized? ○No ○Yes. Why?_____

Has your child ever had surgery? ○ No ○ Yes. What?_____

List any medical problems your child has?

_____

List all medications your child is taking: _____

List any medical or food allergies your child has:_____

Are your child's immunizations up to date? _____

Does your child attend: ○ Daycare ○Preschool ○Elementary ○Middle school ○High school ○ Home school

Are there any other concerns with your child's physical or mental development, speech development, etc?

_____

Family History: Please check any of the following diseases that the parents, siblings, children, or other close relatives have and indicate the relative.

Heart Disease	High Blood Pressure
Stroke	Bleeding Problems
Cancer/Tumors	Kidney Problems
Diabetes	Stomach Problems
Intestinal Problems	Seizures
Headaches	Arthritis at young age
Hearing loss at young age	Any other family illnesses or early deaths

Home Environment:

Does anyone in the home smoke?_____

Does anyone in the home have tuberculosis?_____

Are there pets in the home?_____

Has anyone in the family traveled outside of the country recently? _____If so, where?_____

Were either parents or child born outside of the United States?_____ If so, where?_____

Name of person filling out this form

Signature Date

Relationship to child

Physician only: I have reviewed this note

Physician only: Signature and date