



STEPHEN A. LANDERS, M.D.
 DIPLOMATE, AMERICAN BOARD OF OTOLARYNGOLOGY
 HEAD AND NECK SURGERY
PEDIATRIC HEALTH HISTORY
CONFIDENTIAL

PEDIATRIC AND ADULT
 EAR, NOSE & THROAT

Name _____ Date _____

Reason for Today's Visit

Review of Symptoms/Medical Problems - Check All That Apply

- | | | | |
|--|---|--|---|
| <p>General</p> <input type="checkbox"/> Cancer
<input type="checkbox"/> Diabetes
<input type="checkbox"/> Down Syndrome
<input type="checkbox"/> Fever
<input type="checkbox"/> HIV
<input type="checkbox"/> Weight Change
<input type="checkbox"/> Other _____ | <p>Nose</p> <input type="checkbox"/> Allergies
<input type="checkbox"/> Foreign Body
<input type="checkbox"/> Large Adenoids
<input type="checkbox"/> Nasal Congestion
<input type="checkbox"/> Nasal Drainage
<input type="checkbox"/> Nasal Obstruction
<input type="checkbox"/> Nose Bleed
<input type="checkbox"/> Sinus Infection
<input type="checkbox"/> Other _____ | <p>Lungs</p> <input type="checkbox"/> Asthma
<input type="checkbox"/> Bronchitis
<input type="checkbox"/> Cough
<input type="checkbox"/> Cystic Fibrosis
<input type="checkbox"/> Sleep Apnea
<input type="checkbox"/> Wheeze
<input type="checkbox"/> Other _____ | <p>Muscle-Joint-Bone</p> <input type="checkbox"/> Arthritis
<input type="checkbox"/> Broken Bone
<input type="checkbox"/> Congenital Problem
<input type="checkbox"/> Other _____ |
| <p>Eyes</p> <input type="checkbox"/> Strabismus
<input type="checkbox"/> Vision Loss
<input type="checkbox"/> Other _____ | <p>Throat</p> <input type="checkbox"/> Cleft Lip
<input type="checkbox"/> Cleft Palate
<input type="checkbox"/> Hoarseness
<input type="checkbox"/> Large Tonsils
<input type="checkbox"/> Mouth Breathing
<input type="checkbox"/> Neck Mass
<input type="checkbox"/> Snoring
<input type="checkbox"/> Sore Throat
<input type="checkbox"/> Strep Throat
<input type="checkbox"/> Stridor
<input type="checkbox"/> Tongue Tie
<input type="checkbox"/> Tonsillitis
<input type="checkbox"/> Other _____ | <p>Heart</p> <input type="checkbox"/> Congenital Problem
<input type="checkbox"/> Heart Murmur
<input type="checkbox"/> Other _____ | <p>Genitourinary</p> <input type="checkbox"/> Congenital Problem
<input type="checkbox"/> Hernia
<input type="checkbox"/> Other _____ |
| <p>Ear</p> <input type="checkbox"/> Balance Disturbance
<input type="checkbox"/> Dizziness
<input type="checkbox"/> Ear Drum Perforation
<input type="checkbox"/> Ear Infection
<input type="checkbox"/> Ear Pain
<input type="checkbox"/> Foreign Body
<input type="checkbox"/> Hearing Loss
<input type="checkbox"/> Middle Ear Fluid
<input type="checkbox"/> Ringing in Ear
<input type="checkbox"/> Other _____ | <p>Gastrointestinal</p> <input type="checkbox"/> Abdominal Pain
<input type="checkbox"/> Congenital Problem
<input type="checkbox"/> Nausea
<input type="checkbox"/> Reflux Esophagitis
<input type="checkbox"/> Vomiting
<input type="checkbox"/> Other _____ | <p>Neurologic</p> <input type="checkbox"/> Attention Deficit (ADD)
<input type="checkbox"/> Depression
<input type="checkbox"/> Headache
<input type="checkbox"/> Head Injury
<input type="checkbox"/> Psychiatric Care
<input type="checkbox"/> Seizure
<input type="checkbox"/> Other _____ | |

Consultations for Recurrent Ear Infection
 How many ear infections during past 6 months?
 How many ear infections during past 12 months?

Consultations for Chronic Middle Ear Fluid
 How many months has fluid been present?

Consultations for Chronic Tonsillitis, Pharyngitis, Strep Throat
 How many episodes of the above during the past 6 months?
 How many episodes of the above during the past 12 months?

Consultations for Mouth, Breathing, Snoring, or Sleep Apnea
 Does the patient snore? Every night? Most Nights? Rarely? Never?
 Have you seen patient stop breathing during sleep? Yes No

Is child around second-hand smoke? Yes No Does the child attend school or day care? Yes No

 THE ABOVE INFORMATION IS ACCURATE TO THE BEST OF MY KNOWLEDGE.

Drug Allergies: <input type="checkbox"/> None Known Medications: _____ Previous Surgery/Hospitalization (Year): _____ _____ _____
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 Parent/Guardian

 Date

 Stephen A. Landers, MD

 Date