

T. L. Wood, MD FACS

Today's Date: _____ Patient's Name: _____

Date of Last Physical Exam: _____ Physician's Name: _____

Allergies: _____

Medications: (currently taking) _____

Surgeries: _____ Hospitalizations: _____

Age: _____ Weight: _____ Height: _____ Resp: _____ BP: _____

PLEASE MARK "YES" OR "NO" TO ALL OF THE FOLLOWING QUESTIONS. IT IS IMPORTANT HEALTH HISTORY INFORMATION

Does your child currently have or have you had in the past year?

- | | | | | | | |
|--------------------------|--------------------------|--------------------------|---|--------------------------|--------------------------|---|
| | Yes | No | | Yes | No | |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Any weight change, fever, fatigue | <input type="checkbox"/> | <input type="checkbox"/> | Frequent sore throats |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Easy bruising or bleeding | <input type="checkbox"/> | <input type="checkbox"/> | History of strep throat |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Enlargement / inflammation of lymph nodes | <input type="checkbox"/> | <input type="checkbox"/> | Hoarseness |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Head trauma | <input type="checkbox"/> | <input type="checkbox"/> | Difficulty swallowing |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Headaches | <input type="checkbox"/> | <input type="checkbox"/> | Wheezing, shortness of breath |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Dizziness | <input type="checkbox"/> | <input type="checkbox"/> | Snoring |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Sensitivity to light, double vision | <input type="checkbox"/> | <input type="checkbox"/> | Delayed speech |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Hearing loss | <input type="checkbox"/> | <input type="checkbox"/> | Periods where you stop breathing while sleeping |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Failed hearing test | <input type="checkbox"/> | <input type="checkbox"/> | Neck swelling, goiter |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Earaches | <input type="checkbox"/> | <input type="checkbox"/> | Chronic cough |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Discharge from ears | <input type="checkbox"/> | <input type="checkbox"/> | Asthma |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Frequent ear infections | <input type="checkbox"/> | <input type="checkbox"/> | Allergies / Hayfever |
| | | | How often _____ | | | To what _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Ringing in ears, or fullness in ears | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Chronic nasal congestion | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Sinus problems | <input type="checkbox"/> | <input type="checkbox"/> | Chest pain |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Trauma to nose | <input type="checkbox"/> | <input type="checkbox"/> | Abdominal pain, c/o N&V |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Nosebleeds | <input type="checkbox"/> | <input type="checkbox"/> | Sleep disturbances |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Increase in nasal discharge | <input type="checkbox"/> | <input type="checkbox"/> | Depression or mood swings |
| | | | | <input type="checkbox"/> | <input type="checkbox"/> | Other: _____ |

Past Illness:

- | | | | | | | |
|--------------------------|--------------------------|--------------------------|---------------------|--------------------------|--------------------------|--------------------------------|
| | Yes | No | | Yes | No | |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Measles | <input type="checkbox"/> | <input type="checkbox"/> | Mumps |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Meningitis | <input type="checkbox"/> | <input type="checkbox"/> | Hemophilia / bleeding disorder |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | AIDS (HIV positive) | <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Pneumonia | <input type="checkbox"/> | <input type="checkbox"/> | Other: _____ |

Family History of the patient:

	Age	If living, health	If deceased (age at death / cause)
Father	_____	_____	_____
Mother	_____	_____	_____
Brothers	_____	_____	_____
Sisters	_____	_____	_____

Has any relative ever had the following:

- | | | | | | | | | | |
|--------------------------|--------------------------|--------------------------|---------------------|--------------------------|--------------------------|---------------|--------------------------|--------------------------|--------------|
| | Yes | No | | Yes | No | | Yes | No | |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Cancer | <input type="checkbox"/> | <input type="checkbox"/> | Diabetes | <input type="checkbox"/> | <input type="checkbox"/> | Stroke |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | High Blood Pressure | <input type="checkbox"/> | <input type="checkbox"/> | Heart trouble | <input type="checkbox"/> | <input type="checkbox"/> | Epilepsy |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Tuberculosis | <input type="checkbox"/> | <input type="checkbox"/> | Hemophilia | <input type="checkbox"/> | <input type="checkbox"/> | Other: _____ |

Completed By: _____ Relationship to patient: _____ Date: _____